UNITED
NATIONS

E

Economic and Social Council

Distr.
LIMITED

E/ICEF/1990/P/L.17
26 March 1990

ORIGINAL: ENGLISH

UNITED NATIONS CHILDREN'S FUND
Programme Committee
1990 session

FOR ACTION

RELIEF AND REHABILITATION PROGRAMME

Afghanistan

The Executive Director recommends that the Executive Board approve an amount of $10,000,000 from general resources, subject to the availability of funds, for the relief and rehabilitation programme for Afghanistan for the period 1990 to 1991.

The recommendation is additional to the UNICEF Emergency Appeal for $25,000,000 under the consolidated United Nations programme of humanitarian and economic assistance relating to Afghanistan (SG/Conf.3/1) and the $4,045,000 requested under the appeal for the United Nations Emergency Winter Relief Project.*

* Figures subject to change.

best copy available

CONTENTS

Page

INTRODUCTION 3

THE SITUATION OF CHILDREN AND WOMEN 3

REVIEW OF PAST CO-OPERATION 6

RECOMMENDED PROGRAMME OF CO-OPERATION, 1990-1991 8

BASIC DATA 16

List of tables

1. Breakdown of actual expenditure for general resources and supplementary funding under previous co-operation period, 1988-1989 18

2. Planned expenditure for general resources, new supplementary funding and funded supplementary funding 19

3. Staffing from budget and programme funds 21

Annex. List of studies and evaluations 22

INTRODUCTION

1. During the past decade, an estimated 1 million people have died in Afghanistan, and thousands of others have been disabled. More than 5 million people have fled the country, and it is estimated that a further 2 million have been internally displaced within the country. The remaining population of 10 million to 15 million has suffered considerable hardship from years of war and destruction, including the devastation of the social infrastructure and essential services. It is estimated that 18 to 20 per cent of women are now widows, and many children have been orphaned. The war has produced an extremely high dependency ratio and a significant gender differential. The urban population continues to live under siege and the threat of bombardment. Even before the war, Afghanistan was one of the least developed countries in the world. The conflict has further impoverished the country, wreaking immeasurable social and economic havoc and inflicting unparalleled human suffering.

2. It is against this tragic background that UNICEF, under the aegis of the United Nations Office of Co-ordination for Afghanistan (UNOCA) and in conjunction with other United Nations agencies, has prepared the present programme of relief and rehabilitation assistance for Afghan women and children, wherever they are accessible to outreach programmes from the UNICEF offices at Kabul, the capital, Peshawar, Pakistan and the Islamic Republic of Iran. This programme builds upon the knowledge, experience and expertise gained over the past two years through the expanded programme of immunization (EPI) and the first 18 months of the emergency assistance programme.

3. Despite this bleak picture, the prospects of peace and recovery are better now than at any time in the last decade. An imaginative and flexible response is required to cope with the continuing uncertainty of the situation. Therefore, a short-term proposal for the period 1990-1991 is being presented. An update on activities and, if circumstances warrant, a longer-term submission for 1992 and afterward will be submitted to the Executive Board in 1991.

THE SITUATION OF CHILDREN AND WOMEN

4. Afghanistan is one of the poorest countries in the world with an annual per capita income of about $130. Most of the country is covered by mountains and deserts. Trade and communications among the various regions are difficult; there are no railroads, and only a few paved highways link the major cities. Although limited fertile land and dependence on unreliable winter snow and spring rains hinder the development of agricultural production and livestock farming, by 1974, Afghanistan was self-sufficient in wheat, its most important crop, and by 1978, agricultural products constituted only 15 per cent of total imports.

5. According to a survey carried out by the Swedish Committee for Afghanistan, between 1979 and 1987, food production dropped to 45 per cent, at most, of its pre-war level. The area cultivated by those who were still working their land declined by 30 per cent and their yields fell by an average of 35 per cent. This

was due to a lack of draught oxen (large numbers were killed during the hostilities), difficulty in obtaining fertilizer and the lack of certified seed. As a result, there has been a substantial increase in the price of staple foods (the cost of wheat more than quintupled from 1978 to 1987), and it was estimated in 1988 that food production was 15 per cent below the level required to feed those then living in the country. Recently, localized crops failures, locust infestation and the periodic blockage of supplies owing to the conflict have put a number of rural communities at serious risk. Household food security is tenuous and the situation could soon become critical.

6. Current levels of infant, child and maternal mortality and morbidity are significantly higher than in most other developing countries. According to the United Nations Population Division, the infant mortality rate (IMR) is estimated at 171 per 1,000 live births. There are indications that mortality rates are higher in rural than in urban areas. Diarrhoeal diseases, acute respiratory infections (ARI), measles and other vaccine-preventable diseases, in association with malnutrition, account for more than 50 per cent of infant and child mortality. Maternal mortality was estimated at 690 per 100,000 live births in 1980 and may have increased since. This is due primarily to the lack of pre-natal care, untrained birth attendants and unsanitary delivery conditions.

7. Because of differences in methodology, existing nutrition surveys cannot be used to illustrate trends or be considered representative of the general population. Nevertheless, various studies suggest that malnutrition is a serious problem that cuts across regions and groups. Figures from Kabul-based clinic surveillance activities by UNICEF and the International Committee of the Red Cross (ICRC) indicate that 30 per cent of children under five years of age are moderately malnourished and as many as 10 per cent are severely malnourished. Other nutritional problems include iodine and vitamin A deficiency, anaemia and weanling diarrhoea.

8. Adequate and safe water is a scarce commodity in all areas of Afghanistan. While there are piped water schemes available in larger urban centres, it is estimated that only about 30 per cent of the urban population has access to them. In rural areas, less than 8 per cent of the population has access to piped water supplies. The quality of these water systems is also questionable. All systems of water provision, including wells, have suffered considerable damage owing to the war, in addition to the lack of maintenance and general neglect.

9. Although there was large-scale international assistance to the Afghanistan educational sector in the 1960s and 1970s, success was limited. The literacy rate of about 10 per cent is one of the lowest in the world. Only about 3 per cent of Afghan women are literate. Ten years of war have destroyed the educational infrastructure and disrupted education services. It is currently estimated that over 1,800 schools (66 per cent) have been partially or completely destroyed, the majority being primary schools. In Kabul province, 55 per cent have been damaged; in Balkh and Herat provinces, 73 and 70 per cent, respectively. In addition, 2,000 teachers have been killed, thousands dislocated and more than 10,000 are under arms. Furthermore, the production and distribution of teaching materials have virtually stopped.

READER FICHE

10. There are an estimated 2 million children of primary school age in Afghanistan. Primary school enrolment has fallen from about 30 per cent in 1978-1979 to about 20 per cent in 1986-1987. Girls account for only 18 to 20 per cent of the pupils. Ad hoc estimates suggest a drop-out rate of approximately 50 per cent. In all but a few urban areas, the education system has collapsed. With the exception of Kabul, teacher and vocational training and university education are non-existent. Kabul faces a problem in trying to provide services for an estimated 130,000 internally displaced children. Currently, only 10 per cent of them have access to formal education.

11. More than a decade of civil strife and social disruption has seriously affected the situation of women. Many women have been widowed or have lost children and parents. Despite the fact that women make up more than one half of the human resource potential for rehabilitation and development, to date little investment has been made in developing programmes to build and harness women's resources for self, family, community and national development.

12. In Afghanistan, disability and trauma will remain a permanent, costly reminder of the conflict for years to come. Although the incidence of disability was already high prior to the conflict, an estimated 300,000 to 500,000 Afghans have been disabled as a direct consequence of the war, compounded by a significant increase in the incidence of poliomyelitis, leprosy, tuberculosis and trachoma resulting from the lack of health services. The most visible disabilities are amputation and poliomyelitis. Less noticeable, but present in increasing numbers, are the visually and hearing impaired, as well as the mentally retarded. The problem of mental illness and psychological trauma related to the war appears to be greater than previously recognized and cannot be adequately dealt with by existing services.

13. The numbers of disabled children can be expected to rise with repatriation and increased encounters with ordnance. However, it would be a mistake to focus only on war-related disabilities since the overwhelming majority of children's disabilities are from other causes and are preventable. Currently, a great range of services is provided to Afghan children both within Afghanistan and in Pakistan.

14. Since 1978, more than 5 million Afghans have sought refuge in Pakistan and the Islamic Republic of Iran. Despite the signing of the Geneva Accords, refugees have not yet returned home in any significant numbers. The Afghan refugee population in the Islamic Republic of Iran is estimated at 2.3 million, living largely in the eastern provinces. The refugees have been integrated into Iranian society and generally have access to the same health care, education and social service facilities available to the indigenous population. Under a major programme implemented by the Ministry of Health, a network of primary health care (PHC) centres has been set up in border areas, staffed by specially trained Afghan refugees. Limited assistance has also been provided to some urban refugees.

15. The refugee population in Pakistan is located in over 350 camps close to the border; more than 70 per cent are women and children. It is estimated that one third of all refugee children were born in the camps. While detailed analysis of the status of refugees in the Pakistan camps is difficult, surveys conducted in

1984, 1985 and 1986 by the United States Centres for Disease Control (Atlanta, Georgia), in collaboration with the Office of the United Nations High Commissioner for Refugees (UNHCR), show that IMR decreased by 40 per cent from 156 per 1,000 live births in 1984 to 81 in 1986. Likewise, the neonatal mortality rate decreased by 34 per cent from 61 per 1,000 live births in 1984 to 40 in 1986. The under-five mortality rate (U5MR) declined from 225 per 1,000 live births in 1984 to 121 in 1986. Morbidity patterns show similar declines. UNHCR assists with education for the refugees' children. Some 116,000 children, an estimated 8.6 per cent of eligible children, are enrolled in 456 primary schools in the north-west frontier province. Enrolment in Baluchistan, where fewer schools exist, is somewhat lower, with about 13,000 students attending 113 primary schools.

REVIEW OF PAST CO-OPERATION

16. UNICEF has assisted Afghanistan since 1949, initially with support for maternal and child health (MCH) services, and later with assistance to the education sector. Following the drought of 1970, UNICEF provided assistance for water supplies. A five-year country programme submission was approved in 1978 (E/ICEF/P/L.1741), providing $19.4 million from general resources and $4.3 million from supplementary funding. The major components of the programme were rural development, health services, water supply and non-formal education.

17. A national immunization programme was launched in 1977, but owing to political events and the escalating conflict, activities were limited to the Kabul area. During 1984-1986, the immunization programme was intensified. Coverage surveys at Kabul showed 80 per cent of children under five years of age fully immunized, while 54 per cent of women (15 to 45 years old) were immunized against tetanus.

18. In 1986, following the presentation to the Board of a paper on children in situations of armed conflict (E/ICEF/1986/CRP.2), an agreement was reached to expand the UNICEF programme of assistance to areas outside Kabul. Simultaneously, UNICEF began to explore ways to launch an immunization programme for all Afghan children. The expanded immunization activities started in the summer of 1987 on an experimental basis in the provinces of Paswan, Kunduz and Herat. UNICEF provided vaccines, immunization supplies, cold-chain equipment and training support. Following the success of this pilot project, the second phase, serving 10 additional provinces, began in 1988.

19. In 1987, with the agreement of all parties, UNICEF expanded its immunization programme to the refugee camps, in collaboration with UNHCR and the Government of Pakistan. Support was also extended to selected non-governmental organizations (NGOs) and voluntary groups so that they could carry out immunization activities organized by local community-based organizations and local leaders inside Afghanistan.

20. To date, sound and effective co-operation has been established with the Ministry of Health and 10 NGOs, as well as with UNHCR and EPI counterparts from the Government of Pakistan. In addition to the mobile teams working in the urban areas, over 49 vaccination teams have been deployed in 45 districts. There has

been a significant increase in EPI coverage levels in both Afghanistan and the refugee camps in 1989.

21. Following the signing of the Geneva Accords and the appointment by the Secretary-General of a co-ordinator for humanitarian efforts in 1988, UNICEF presented a $25 million appeal as part of the co-ordinated United Nations appeal for Afghanistan. The major goal of the appeal was to meet the basic survival needs of all Afghan children and women, whether in urban and rural Afghanistan or in surrounding countries. To date, $10.6 million has been raised, leaving an unfunded balance of $14.4 million. Expenditure as of the end of 1989 was estimated at $8.6 million.

22. The emergency appeal enabled UNICEF to assist 10 projects in refugee camps and 17 projects in rural Afghanistan in the areas of health, EPI, education, training, health education and area-based social development. In addition, UNICEF has expanded its activities outside Kabul into the provincial capitals of Herat and Mazar-i-Sharif.

23. In May 1989, a control of diarrhoeal diseases (CDD) campaign was launched. Activities included the production (with UNICEF assistance) of 750,000 packets of oral rehydration salts (ORS) and the distribution of 483,000 ORS packets, together with 32,000 leaflets and posters to 300 distribution centres comprising health facilities, schools, day-care centres and pharmacies. A major achievement was the distribution of 433,000 ORS packets to facilities outside the capital. UNICEF also supported the production of a videotape on the preparation of ORS solutions and the prevention of dehydration, which was aired extensively.

24. A sanitation campaign was launched along with the CDD campaign. It included intensive advocacy, using vans equipped with public address systems, plus radio and television spots, the training of community and religious leaders and the mobilization of communities for self help. UNICEF also expanded its assistance to the provision of safe water supplies in health and education institutions, mosques and community centres, and the construction of demonstration latrines in selected communities.

25. In the field of nutrition, UNICEF, through the United Nations humanitarian programme, provided sugar, powdered milk, wheat, rice, vetch and rice flour to MCH clinics for malnourished children. The aim was both to feed the children and to educate the mothers through demonstration. UNICEF also supported nutrition-orientation courses for nurses and arranged the translation of a booklet on breast-feeding and contraception into a local language (Dari), as well as its distribution to health institutions and schools.

26. During the summer of 1989, UNICEF successfully delivered essential supplies to Afghanistan. Despite logistical problems caused by poor road conditions, security problems and the need to deal with multiple authorities, UNICEF has distributed to date over 350 emergency health kits and drug kits to 6 children's hospitals, 30 MCH centres, 18 basic health units and other health facilities in Herat, Farah, Badakshan and Balkh provinces. Over 700 emergency kits are stockpiled inside Afghanistan at various locations for distribution according to assessed needs.

27. During the winter of 1989-1990, UNICEF, in collaboration with other United Nations agencies, launched an appeal for $4 million, plus 2,000 tons of high-protein food to undertake a four-month emergency winter relief project to protect vulnerable groups in Kabul City and six northern provinces. The project included the distribution of blankets and soap, supplementary feeding assistance, emergency MCH/PHC assistance, emergency rehabilitation of the children's hospital and the supply of emergency medical supplies.

RECOMMENDED PROGRAMME OF CO-OPERATION, 1990-1991

Recommended general resources: $10 000 000

Recommended programme co-operation

(Thousands of United States dollars)

	Amount
Emergency relief and response	2 000
Health and nutrition	5 000
Water and environmental sanitation	300
Children and women with special needs	500
Education	600
Advocacy	100
Planning	100
Programme support	1 400
Total	10 000

28. The initial phase of the relief and rehabilitation programme covers a period of 24 months, from January 1990 to December 1991. The goal is to meet the basic survival needs of all Afghan children and women. The programme includes support for emergency relief needs, essential child survival interventions, assistance for women and children with special needs and assistance for the support and rehabilitation of essential services.

Strategy

29. Given the nature of the current conflict, the programme has been based on certain principles, the first of which is that humanitarian assistance should be extended to all Afghan children wherever they are. The programme will also need to be decentralized to the provincial, district and sometimes village levels, working

with whatever civil or local administration is available. In addition, the programme will remain flexible in order to respond rapidly as the situation changes for children and women. Finally, operational necessity will require that most assistance be concentrated in relatively secure and politically stable areas.

30. UNICEF will continue to focus its interventions, in the first instance, on the large majority of Afghan children and women who have not received basic humanitarian assistance during the armed conflict. Programme activities will be designed to respond and adjust to the existing and changing realities of Afghanistan. Despite the continuing hostilities, recent experience has shown that by working with a number of different partners, it is possible to extend services beyond Kabul to provincial capitals and into rural areas.

31. For the immediate future, major emphasis will be placed on immunization, CDD and the provision of emergency supplies. However, small-scale activities will be carried out in a number of other important areas with a view to developing guidelines for future programming and provision will be made for rehabilitating the health and primary education infrastructure as and when possible.

32. In urban areas, the success and experience gained in providing immunization and other essential health services over the last 10 years will be the basis for the provision of other services. The targeting of services at the community level, with and through identified local leaders, will continue. UNICEF will pursue its efforts to use urban centres for delivering goods to neighbouring rural areas.

33. NGOs will continue to receive extensive UNICEF assistance as collaborating partners in the provision of essential services in rural Afghanistan. UNICEF continues to identify, assist and strengthen the capacity of emerging Afghan community organizations. As the conflict changes, UNICEF will increase its capacity to negotiate and contact local leaders and communities directly. At this stage of the conflict, programme development will not be uniform throughout the country or even within individual provinces, nor will it necessarily be integrated. The mix of activities will vary from valley to valley, reflecting the decentralized and flexible nature of the programme.

34. In refugee camps in Pakistan, co-operation with UNHCR will be increased and strengthened in order to ensure the provision of basic services to the refugee population. UNICEF will continue its extensive assistance to UNHCR to provide immunization for all Afghan children and women before the end of 1990. UNICEF will also assist various NGOs working in the refugee camps to provide training that will equip the refugees for their return home and in the rehabilitation and reconstruction of their society.

35. The opening of a UNICEF Afghan Programme Office in the Islamic Republic of Iran will greatly facilitate the expansion of services to Afghan refugees living in that country. The focus will be on improving health services for 1 million children and women, including immunization, CDD and vitamin supplementation. Every mother and child will be registered, and mothers will be trained in MCH. Eligible Afghans will be included in health education and standard health training courses.

Emergency response and preparedness capability

36. Given the continuing nature of the conflict, UNICEF will, as a priority, strengthen within its office and programme an emergency response and preparedness capability to minimize the impact of the conflict on the most vulnerable groups. In the Kabul office, five international staff with experience in emergency situations, and the necessary support personnel, will be responsible for all preparedness activities and surveillance of the vulnerable groups. A priority task will be the collection of data and the setting up of early warning mechanisms in collaboration with the other United Nations agencies. In addition, the team will participate in Salam (Peace) mobility units (multi-agency visits into rural areas) to be fielded by the United Nations Afghan Co-ordinator. The units will be composed of representatives of each operational United Nations agency and will carry out rapid assessments and initiate projects to respond to the priority needs of the population in the relatively peaceful areas of Afghanistan. Their main counterparts will be local leaders, community councils and village elders.

37. The creation of the team will enable UNICEF to have an extensive field presence and to expand its activities further into rural areas. In this connection, a number of regional supply centres will be established with UNICEF assistance in Afghanistan in order to pre-position essential drugs, emergency health kits and other essential supplies that can be immediately delivered following needs-assessment missions.

Child survival activities

38. The expansion of immunization activities throughout Afghanistan in 1989 clearly demonstrated that, while difficult, immunization activities can be undertaken in most parts of the country.

39. The goal for 1990 will be to attain 80 per cent coverage of children under two years of age and 60 per cent tetanus coverage for women 15 to 45 years of age in Kabul. Immunization activities will be expanded to other urban areas as they become accessible. A complete reorganization of the central cold-chain system, as well as the development of regional cold-chain facilities, will be required.

40. In rural Afghanistan, UNICEF will consolidate its immunization programme by supporting 10 NGOs. Targets for the programme are to provide immunization services to 320,000 children and 125,000 women. UNICEF will provide funds for the training of vaccinators, as well as vaccines, syringes and needles, cold-chain equipment and technical assistance. Co-operation with the World Health Organization (WHO) will be strengthened in the development of joint storage capacity at the district level. Co-operation with the United Nations Logistical and Transport Operation will facilitate the transportation of UNICEF supplies and equipment inside Afghanistan.

41. In its CDD activities, UNICEF will continue to support ORS production in Kabul through the provision of raw materials and packaging materials. The objective of the current project is to reduce morbidity and mortality caused by dehydration related to diarrhoeal diseases. To achieve this, 3 million ORS packets will be

produced and distributed to all health institutions and through vaccination teams and rural health units. Extensive training in the use of ORS will be provided to 800 medical personnel, women's club members, teachers, community and religious leaders. In addition, radio and television broadcasts will be targeted at mothers. In so far as possible, a multifaceted approach to the prevention of diarrheoal diseases will be adopted utilizing health education messages, increasing access to safe water supplies and improving environmental sanitation conditions.

42. ORS will be supplied to rural Afghanistan through all NGOs providing medical assistance. In addition, regular supplies of ORS will be distributed in the refugee camps in Pakistan and the Islamic Republic of Iran through UNHCR health units and through mobile vaccinations teams.

Maternal and child health services

43. Currently, nutritional deficiencies, poor pre-natal care, post-partum infections, low birth weight, measles, diarrhoeal diseases and malnutrition, illiteracy and poor environmental conditions constitute a major threat to the lives and health of Afghan children and mothers. These vulnerable groups urgently need adequate MCH services. Existing facilities are largely cure-oriented and lack adequate referral mechanisms.

44. UNICEF has been supporting the gradual improvement of PHC centres by providing medical supplies and equipment, including essential drugs. In addition to Kabul, assistance has been provided to 10 provinces and recently to the cities of Herat and Mazar-i-Sharif. A great need still exists in urban areas, however, and this assistance will continue. In addition, the number of MCH and basic health centres will be expanded, initially by repairing and maintaining the existing physical infrastructure, and MCH training will be provided to existing health personnel.

45. In rural Afghanistan, UNICEF will continue to assist MCH activities provided by NGOs. A priority task for the new programme will be to expand substantially the number of trained female birth attendants and female health workers. Other UNICEF support will include the provision of MCH training materials, medicines, micronutrient supplements, weighing scales and medical equipment, as well as iron sheets and cement for the physical rehabilitation of health facilities in areas where there are ongoing health projects and evidence of community support. In the refugee camps, UNICEF will continue to support NGO-run clinics and the training of female health workers. UNICEF will also continue to provide medical supplies to UNHCR for MCH clinics.

46. Health education activities will continue with the finalization of a health-care curriculum for primary schools, the production of health messages and the broadcast of health messages and a Facts for Life series.

47. ARI is a major health problem for children under five years of age in Afghanistan. Although the health system has provided some care to children with ARI, no guidelines have been issued for case management at different levels of health facilities and no training has been undertaken. The following activities will be initiated: the preparation of technical guidelines on case management

based upon WHO/UNICEF recommendations; the training of health staff in the diagnosis of ARI, clinical management and prescription and the use of drugs; the development of appropriate communication materials on ARI; and the organization of workshops and seminars to develop strategies for ARI programming.

48. In responding to the declining nutritional status of vulnerable groups, efforts will be focused on ways to attack the major underlying causes of malnutrition, such as inadequate food intake, ignorance and infections. UNICEF will continue to monitor the nutritional status of vulnerable groups and conduct market price surveys to determine food availability. Growth monitoring activities will be strengthened in MCH clinics, and support to intensive feeding units will be continued as necessary. Since vitamin A deficiency, nutritional anaemia and endemic goitre are major public health problems, vitamin A and iron supplementation will be instituted through all existing health facilities and NGO vaccination teams, and UNICEF will support an experimental NGO project to distribute iodine tablets in Badakshan province. Non-formal nutrition education will also be stressed as an important element in addressing problems associated with weaning and post-weaning practices.

Water and environmental sanitation

49. Safe water systems are urgently needed in both the urban and rural areas of Afghanistan. In many areas, water supplies are inadequate owing to neglect and as a consequence of the war. The goal of UNICEF assistance in this area is to reduce water-borne diseases by providing adequate clean water supplies and sanitation facilities. The first priority will be the emergency rehabilitation of community water services, including institutional sources, such as hospitals, clinics and schools. In urban areas with large populations, stand-pipe supply systems may have to be set up.

50. With substantial access to provincial cities for the first time in 10 years, it now seems possible to expand activities into selected rural areas. The rehabilitation programme will give priority to the repair of existing drinking water supply systems. Emergency water systems will be provided on a limited basis to those villages to which large numbers of displaced persons and refugees have returned. In addition, UNICEF will supply hand-pumps to local communities that will undertake the digging of wells. Efforts will also be made through food-for-work projects (with the World Food Programme (WFP)) and cash-for-work programmes to repair existing drinking water supply systems and to expand their output both in rural and urban areas.

Children in difficult circumstances

51. The safety and protection of children psychologically or physically traumatized by the last 10 years of conflict is a matter of increasing concern to UNICEF. Based on survey data (Sliwinski, 1988), it is estimated that 19 per cent of Afghan refugee children in Pakistan are orphans. This suggests that there may be more than 500,000 orphans and fatherless children in Afghanistan. Studies will be carried out to determine the situation of these children, as well as to identify the psychological support needs of children who have been traumatized by the

ongoing war, and small-scale activities will be developed to deal with the most pressing problems.

Disabled children

52. It is estimated that there may be as many as 100,000 disabled children. In order to develop an effective response, a study will be undertaken to assess the magnitude of the problem of disability and identify needs. Pending the results of the survey, assistance will be made available for staff training and the development of advocacy materials for the prevention of disability. Supplies and equipment will be provided to institutions working in this area. UNICEF is already assisting an NGO team at Kabul to expand its prosthetics capacity, as well as its training of prosthetics makers. Negotiations have begun with a number of other NGOs to provide further services for the disabled.

53. The prevention of further disabilities is of paramount importance to UNICEF. Immunization services, health education, proper nutrition and micronutrient supplementation will all assist in preventing further disabilities. UNICEF will continue to finance a series of radio broadcasts on the Pashtu service of the British Broadcasting Corporation on health and disability topics.

Women with special needs

54. No systematic analysis of the situation of women has been undertaken. However, there is ample evidence to suggest that vulnerable women - the disabled, those caring for disabled men, widows and those living in poverty - now constitute a large part of the Afghan population. Programmes to assist these women are urgently required. To this effect, UNICEF and the United Nations Development Fund for Women held a joint workshop to help in the planning of programmes for Afghan women, including the most vulnerable groups. Skills training, literacy, access to health care and gainful employment opportunities have all been identified as entry points to assist women in difficult circumstances. Experimental projects in each of those areas will be undertaken at community and household levels where the most needy women can easily be identified. At the same time, community projects will ensure that these women are reached within their traditional social environment.

Education

55. Within the overall programme, special emphasis on the rehabilitation of the education system is a priority. Although it is unrealistic at this time to suggest a country-wide activity, support to ongoing education activities in Kabul and other urban centres, as well as to expansion of primary education in the rural areas, is feasible.

56. In Kabul and other urban areas, UNICEF will strengthen and improve the quality of primary education by rehabilitating 100 existing facilities. In addition, assistance will be provided for appropriate teaching aids, essential class-room supplies and furniture. To provide access to primary education for the internally displaced communities residing in urban areas, UNICEF, together with other partners, will develop a basic education programme package based on survival needs and skills training, and will assist in expanding school premises.

57. In rural Afghanistan, UNICEF will continue to support selected NGOs working in the education sector. Through the Afghan Education Committee and Muslim Aid, UNICEF will support the pre- and in-service training of 1,300 teachers. Assistance will also include the supply of books, teaching materials, stipends, salaries and transport. UNICEF will provide support for directly sustaining the participation of 41,000 children in 245 schools through the Afghan Education Committee. UNICEF will also assist in the reconstruction and rehabilitation of primary schools mainly by providing cement and galvanized iron sheets to communities where a school is already functioning.

Co-operation with other agencies

58. UNICEF is a major multilateral donor in Afghanistan, having successfully maintained an active role throughout the 1980s. UNICEF was an early and active supporter of a large-scale expansion of United Nations system activities in Afghanistan. In this respect, UNICEF also urged the creation of a high-level co-ordinating body to mobilize significantly larger resources and expanded activities.

59. Since the creation of the United Nations Co-ordinator's Office, UNICEF has been actively involved in its work and has participated in many Salam missions and in the various field visits outside Kabul. UNICEF has designated a special co-ordinator in New York who liaises closely with the Office. Support for the work of the Co-ordinator and his representatives remains an important priority for UNICEF both at headquarters and in the field.

60. The UNICEF relief and rehabilitation programme has been developed within the framework of the joint United Nations plan for humanitarian assistance for Afghanistan. UNICEF has planned the proposed activities in close co-ordination with UNOCA and with other United Nations agencies, such as the United Nations Development Programme (UNDP), UNHCR, WHO, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Development Fund for Women and WFP.

61. Many NGOs have developed extensive programmes in rural Afghanistan and have won the confidence of the local leadership and population. Their experience and expertise will be an invaluable asset to UNICEF, and further close co-operation with a number of NGOs is planned under this programme.

Monitoring and evaluation

62. Activities focused on urban centres, and their surrounding areas will be monitored through health facility records, consultations with ministry officials, joint missions sponsored by UNOCA and field visits by UNICEF staff.

63. The monitoring and evaluation of NGO activities in rural areas will be achieved through their progress reports, as well as through visits by UNICEF staff and joint United Nations missions. The UNHCR programme in Pakistan refugee camps will be monitored and evaluated in accordance with established UNHCR procedures and regular UNHCR/UNICEF evaluations.

Programme administration

64. The UNICEF relief and rehabilitation programme is co-ordinated from New York headquarters by a co-ordinator who acts on behalf of the Executive Director and operates under the guidance of the Deputy Executive Director, Programmes. The Co-ordinator is supported by the Afghan Unit staff in New York and receives liaison support from the Emergency Operations Officer at Geneva.

65. In the field, the UNICEF programme is implemented under the overall guidance and supervision of the Co-ordinator, by the Afghan country office at Kabul and by an Afghan programme office located at Peshawar. The Peshawar office is responsible for programme implementation and monitoring with NGOs and in the refugee camps. Negotiations are under way with the Islamic Republic of Iran to open an Afghan programme office responsible for refugees located in that country.

AFGHANISTAN

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	300	(1988)	Very High U5MR
Infant mortality rate	171	(1988)	Very High IMR
GNP per capita	$130*	(1987)	Low GNP
Total population	15 million	(1988)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1988
Births	(thousands)	716	773	756	843
Infant deaths (under 1)	(thousands)	142	141	134	144
Under-five deaths	(thousands)	249	248	235	253
Under-five mortality rate (per 1,000 live births)		348	321	311	300
Infant mortality rate (under 1) (per 1,000 live births)		198	183	177	171

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980)	Moderate & severe	38*	..
	Severe	7*	..
Babies with low birth weight (%, 1979/1987)		20	19*
Children completing primary level (% of first grade, 1980/1986)		54	63

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1983)		.. /.. /..	.. /74a/61a/
Prevalence of wasting (%)		..	..
Prevalence of stunting (%)		..	..
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)		94	..
Food production per capita index (Index 1979-1981=100, 1980/1987)		100	..
Household expenditure (% of total income)	All food/cereals	../..	../..

HEALTH INDICATORS		About 1980	Most recent
ORS use rate (%, 1986-1987)			11
Access to health services	Total	..	29*
(% of population, 1986)	Urban/rural	../..	80*/17*
Access to safe water	Total	11	21
(% of population, 1980/1986)	Urban/rural	28/8	38 /17
Access to adequate sanitation	Total	..	
(% of population, 1986)	Urban/rural	../..	5 /..
Births attended by trained personnel (%, 1977/1988)		5	8
Maternal mortality rate (per 100,000 live births, 1975)		690	..

Immunization		1981	1985	1987	1988
One-year-olds (%) immunized against:	Tuberculosis	8	17	27	35
	DPT	3	15	25	31
	Polio	3	15	25	31
	Measles	6	14	31	30
Pregnant women (%) immunized against	Tetanus	3	11	6	9

AFGHANISTAN

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	300	(1988)	Very high U5MR
Infant mortality rate	171	(1988)	Very high IMR
GNP per capita	$130*	(1987)	Low GNP

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	33/29	21 /..
(%, 1980/1987)	Male	54/46	27 /..
	Female	12/11	14 /..
Secondary enrolment ratio (gross/net)	Total	10/..	7 /..
(%, 1980/1987)	Male	16/..	10 /..
	Female	4/..	5 /..
Adult literacy rate, 15 years & older	Total	8	10*
(%, 1970/1987)	Male/female	13/2	17*/3*
Radio/television sets (per 1,000 population, 1980/1987)		75/3	102/8

DEMOGRAPHIC INDICATORS		1970	1980	1985	1988	2000**
Total population	(millions)	13.6	16.1	14.5	15.1	26.6
Population aged 0-15 years	(millions)	..	7.3	6.4	6.7	11.9
Population aged 0-4 years	(millions)	..	2.6	2.4	2.6	4.8
Urban population (% of total)		11	16	19	20	29
Life expectancy at birth (years)	Total	37	40	41	42	46
	Male/female	37/37	40/41	41/42	41/42	46/47
Total fertility rate		7.1	7.1	6.9	6.9	5.9
Crude birth rate (per 1,000 population)		52	50	49	49	44
Crude death rate (per 1,000 population)		27	24	23	23	18

		About 1980	Most recent
Contraceptive prevalence rate (%, 1973)		2	..
Population annual growth rate	Total	2.4	-0.8
(%, 1965-1980/1980-1988)	Urban	6.0	0.2

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980)		0.6	..
Inflation rate (%, 1965-1980)		5	..
Population in absolute poverty (%, 1977)	Urban/rural	18/36	../..
Household income share (%)	Top 20%/bottom 40%	../..	../..
Government expenditure	Health/education	../..	../..
(% of total expenditure)	Defence	..	..
Household expenditure (% of total income)	Health/education	../..	../..
Official development assistance:	US$ millions	32	17*
(1980/1986)	As % of GNP	2	..
Debt service (% of goods & services exports)		..	..

a/ Kabul only.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 1. BREAKDOWN OF ACTUAL EXPENDITURE FOR GENERAL RESOURCES AND SUPPLEMENTARY FUNDING UNDER PREVIOUS CO-OPERATION PERIOD, 1988-1989

(Thousands of United States dollars)

COUNTRY: AFGHANISTAN REHABILITATION

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	SF	GR	SF	GR	SF	GR	SF	GR	SF	Total
Health		1008		5		255		377		1645	1645
Water supply and sanitation		10								10	10
Emergency		3017		20		419		1232		4689	4689
Planning and project support		26						17		43	43
Freight		240						1590		1830	1830
GRAND TOTAL		4300		25		675		3218		8217	8217

GR = General resources.
SF = Supplementary funding.

TABLE 2. PLANNED EXPENDITURE FOR GENERAL RESOURCES, NEW SUPPLEMENTARY FUNDING AND FUNDED SUPPLEMENTARY FUNDING

(Thousands of United States dollars)

Country: AFGHANISTAN REHABILITATION Period covered: 1990-1991	Funding status	1990	1991	1992	1993	1994	Total
Health							
Immunization	GR	850	1150				2000
	FSF	720					720
	USF	3100	2000				5100
Control of diarrhoeal diseases	GR	250	250				500
	USF	300	100				400
Other health	GR	1050	1150				2200
	FSF	200					200
	USF	700	500				1200
Subtotal, Health	GR	2150	2550				4700
	FSF	920					920
	USF	4100	2600				6700
Water supply and sanitation	GR	150	150				300
	USF	500	300				800
Nutrition	GR	150	150				300
	USF	800	500				1300
Education	GR	300	300				600
	FSF	200					200
	USF	1600	1000				2600
Community organization and development	FSF	150					150
	USF	300	100				400
Women-centred programme	GR	100	100				200
	USF	300	100				400
Children in especially difficult circumstances	GR	150	150				300
	USF	500	300				800
Advocacy	GR	50	50				100
Planning and project support	GR	50	50				100
	USF	100					100
Emergency preparedness and winter relief programme	GR	1000	1000				2000
	FSF	1400					1400
	USF	2600					2600

/...

TABLE 2. PLANNED EXPENDITURE FOR GENERAL RESOURCES, NEW SUPPLEMENTARY FUNDING AND FUNDED SUPPLEMENTARY FUNDING (continued)

(Thousands of United States dollars)

Country: AFGHANISTAN REHABILITATION Period covered: 1990-1991	Funding status	1990	1991	1992	1993	1994	Total
Programme support	GR	900	500				1400
	FSF	330					330
	USF	800	500				1300
TOTAL	GR	5000	5000				10000
	FSF	3000					3000
	USF	11600	5400				17000
GRAND TOTAL		19600	10400				30000

GR = General resources.
FSF = Funded supplementary funding.
USF = Unfunded supplementary funding.

/...

TABLE 3. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: AFGHANISTAN REHABILITATION	Number of posts	1990-1991 amount (Thousands of US dollars)
FINANCED FROM 1990-1991 APPROVED BUDGET:		
International Professional established posts	1	212
Local national Professional and General Service established posts	13	334
Operating costs		395
Total	14	941
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	6	1062
Supplementary funds	12	2164
Local national Professional and General Service project posts		
General resources	13	724
Supplementary funds	18	518
Total	49 b/	4468

a/ For information source, see 1990 post authorization table, revised October 1989.

b/ Posts are distributed among Afghanistan, the Afghanistan programme office in Pakistan and the Afghanistan Unit in New York; additional Professional and General Service posts may be created if substantial supplementary funds are received.

Annex

LIST OF STUDIES AND EVALUATIONS

Health and nutrition

1. An overview of the situation of food and agriculture in Afghanistan. UNICEF, August 1987.

2. First quarter health report. UNHCR, June 1989.

3. Acceleration of EPI to Afghan refugees in Northwest Frontier province, Pakistan. UNHCR, August 1988.

4. Report on the expanded programme of immunization for Afghanistan refugees health programme. UNHCR, 1988.

5. EPI programme for Afghan children everywhere. Progress report. UNICEF 1988.

6. A multiple food distribution approach in Afghanistan: coping with the problems. The Agency Coordinating Body for Afghan Relief (ACBAR), March 1989.

7. The agricultural survey of Afghanistan. First report. The Swedish Committee for Afghanistan, May 1988.

8. Health and nutrition in Afghanistan. UNICEF, September 1989.

9. EPI coverage survey (Kabul). UNICEF, October 1988.

10. Diarrhoeal diseases: mortality, morbidity and treatment practices survey in Kabul City. UNICEF, August 1989.

General

11. Office of the United Nations Co-ordinator for Humanitarian Economic Assistance Programmes Relating to Afghanistan. First consolidated report. UNOCA, September 1988.

12. Development co-operation Afghanistan, 1988 report. UNDP, July 1989.

13. "Afghanistan: The Decimation of a People", Marek Sliwinski, Orbis, winter 1989.

14. Status of primary education in Afghanistan. Report of a consultancy visit. UNICEF, December 1989.

15. Afghanistan Committee on Assistance to Disabled Afghans guidelines - prevention of disabilities. May 1989.

16. Afghan women and planning report from a workshop. UNIFEM and UNICEF, September 1989.

17. Women in Afghanistan, preliminary needs assessment. UNIFEM, July 1989.

18. Appraisal of existing water supply to Herat Province and Kabul. UNHCR, September 1988.

19. Supply - logistics mission to Afghanistan. UNICEF, October/November 1989.

UNITED
NATIONS

E

Economic and Social Council

Distr.
LIMITED

E/ICEF/1990/P/L.18
21 March 1990

ORIGINAL: ENGLISH

UNITED NATIONS CHILDREN'S FUND
Programme Committee
1990 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Indonesia

The Executive Director recommends that the Executive Board approve an amount of $62,450,000 from general resources, subject to the availability of funds, and an amount of $32,200,000 in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme of Indonesia for the period 1990 to 1995.

* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme co-operation at the end of 1989, will be contained in the "Summary of 1990 recommendations for general resources and supplementary funding programmes" (E/ICEF/1990/P/L.1).

CONTENTS

Page

THE SITUATION OF CHILDREN AND WOMEN 3

PROGRAMME CO-OPERATION, 1985-1989 4

RECOMMENDED PROGRAMME CO-OPERATION, 1990-1995 8

BASIC DATA 19

List of tables

1. Breakdown of actual expenditure for general resources and supplementary funding under previous co-operation period, 1985-1989 21

2. Planned expenditure for general resources, new supplementary funding and funded supplementary funding 22

3. Staffing from budget and programme funds 23

Annex. Selected list of studies and evaluations 24

THE SITUATION OF CHILDREN AND WOMEN

1. During the 1970s, Indonesia experienced rapid growth in income, consumption and investments, coupled with a reduction in poverty. Since 1981, however, the economy has deteriorated, owing largely to the sharp decline in oil prices. In response, the Government has introduced a number of new policies to reduce dependence on oil as a source of foreign exchange and budgetary revenues. These measures have strengthened prospects for long-term economic growth and financial stability.

2. Indonesia has also made progress in child survival and development (CSD). According to government statistics, the infant mortality rate (IMR) declined by 18 per cent between 1985 and 1988, from 71 to 58 per 1,000 live births. However, according to the Population Division of the United Nations Secretariat, IMR for 1988 is 84 per 1,000 live births. Nevertheless, nearly 300,000 of the 5 million infants born each year die before reaching their first birthday. Four major causes account for 75 per cent of these infant deaths: vaccine-preventable diseases; perinatal causes; dehydration due to diarrhoea; and acute respiratory infections (ARI). Those factors, together with malaria and accidents, accounted for about 73 per cent of child deaths (ages one to four years) between 1980 and 1988.

3. The growth and development of children who survive their first year of life are often impeded by nutritional problems. Nearly 10 per cent of all Indonesian children have moderate protein-energy malnutrition, and 1.3 per cent (about 300,000) are severely undernourished. In addition, vitamin A deficiency causes xerophthalmia in about 160,000 young children. In fact, fewer than half of the country's children under five years old are classified as well nourished, and low nutrition status often exacerbates the causes of infant and child mortality outlined above.

4. Children under five years old, who make up less than 15 per cent of the population, account for 28 per cent of all morbidity. ARI accounts for approximately 40 per cent of under-five morbidity, diarrhoea for 11 per cent and skin infections for another 14 per cent. These three diseases alone cause two thirds of reported illness among young children.

5. The maternal mortality rate (MMR) is estimated at 450 per 100,000 live births. Major causes are toxaemia, haemorrhage and infections, often complicated by underlying malnutrition and anaemia. Nutritional anaemia (iron deficiency) is a major risk factor in both pregnancy and early childhood growth.

6. At least 10 million Indonesians are afflicted by goitre and several million more by more serious forms of iodine deficiency disorders (IDD), such as cretinism.

7. Indonesia is progressing towards basic education for all. Literacy rates are currently estimated at 88 per cent for males and 70 per cent for females aged 15 years and above. Some 94 per cent of boys and girls aged 7 to 12 years enrol in primary school, and about 80 per cent of these complete grade six.

8. Although still primarily a rural country, Indonesia is urbanizing rapidly. At current growth rates, the number of urban dwellers will increase from 43 million in

1985 (26 per cent of the total population) to 73.5 million (36 per cent of the total population) by 1995. This means that the number of children aged 0 to 4 years living in urban areas may increase from 5.2 million in 1985 to more than 9 million by 1995.

PROGRAMME CO-OPERATION, 1985-1989

Health

9. In 1986, President Soeharto declared the decade for Indonesian children and designated the community-organized integrated service post (posyandu) as the core component of the national strategy for the development of young children. The posyandu provides services in immunization, child growth monitoring, the control of diarrhoeal diseases (CDD), antenatal care and family planning. In 1987, the Government initiated an accelerated expansion of the posyandu system to provide access to basic services for all children under five years old, two years ahead of the original schedule. Between 1987 and 1989, 67,000 new posts were established, bringing the total to more than 200,000 in 49,000 villages, thus providing access to an estimated 80 per cent of the country's 23 million children under five years old. This rapid expansion required reprogramming of both government and UNICEF expenditures and a major effort to mobilize adequate human resources for proper implementation.

10. The Pembinaan Kesejahteraen Keluarga (family welfare movement) has played a particularly important role by providing the bulk of the female volunteer workers to fill the additional posts. Social mobilization to promote the use of posyandu services, particularly immunization and oral rehydration therapy (ORT), was also provided by women's branches of 17 religious non-governmental organizations (NGOs) through the UNICEF-supported child survival project. The family welfare movement received the UNICEF Maurice Pate Award and the World Health Organization (WHO) Sasakawa Award in 1988 for its work in support of posyandus and in promoting CSD. This acceleration has cleared the way for efforts to consolidate service delivery and close the gap between access, coverage (first contact), attendance (regular visits) and outcome (e.g., monthly weight gain). The 1988-1989 rates for those are 85, 77, 47 and 25 per cent, respectively.

11. The expanded programme on immunization (EPI) and family nutrition improvement services received UNICEF assistance nation-wide. UNICEF assistance to other programmes has focused on bringing new or improved services to 16 disadvantaged districts in the provinces of West Java, West Sumatera, South Sulawesi, West Nusa Tenggara and East Nusa Tenggara, and to low-income neighbourhoods (kampungs) in seven major cities (Bandung, Semarang, Samarinda, Banjarmasin, Medan, Bandar Lampung and Padang).

12. Indonesia expects to achieve universal child immunization (UCI) by the end of 1990. In early 1989, the reported coverage rates were: 86 per cent with anti-tuberculosis vaccine; 75 per cent for three doses of combined diphtheria/pertussis/tetanus vaccine; 76 per cent for three doses of oral polio vaccines; and 68 per cent for measles. In an effort to raise measles vaccine

coverage, immunization service providers have been instructed to give priority to measles vaccination after a child reaches nine months of age. Previously, the tendency was to wait until the diphtheria/pertussis/tetanus and oral polio vaccines series were complete before administering the measles vaccine. By that time many children were over age.

13. UNICEF provided vaccination kits, 840 refrigerators and seven cold rooms nation-wide. UNICEF steam sterilizers were provided in 17 provinces; the remaining 10 provinces will receive them from other donors in 1990. Training in proper sterilization practices is under way for about 5,500 health centre doctors, who are responsible for training their vaccinators. Rotary International is contributing $6,150,000 to supply 108 million doses of oral polio vaccines in 1987-1991 through its PolioPlus programme.

14. There has been a groundswell of awareness of the value of immunization among policy-makers, health-care providers and the public. This is the result of a wide range of social mobilization efforts such as the nation-wide distribution of a poster of the President giving polio vaccine to a child for EPI promotion; increased involvement of the family welfare movement in registering and motivating women for vaccination; and increased support for UCI from religious figures and NGOs.

15. The CDD project has focused on increasing community awareness of the risks of diarrhoeal dehydration and promoting the early and effective use of ORT/oral rehydration salts (ORS) to prevent diarrhoea-related deaths among children under five years old. In addition to the provision of ORS, which is now locally produced, private advertizing and research agencies were used to position and market appropriate messages through radio, sign boards, posters, newspapers, posyandu cadres and primary school teachers.

16. Studies of performance by traditional birth attendants (TBAs) show that training without supervision does little to improve delivery practices. Thus, in addition to the training of 20,500 TBAs in safe delivery procedures, "mother awareness" training for 1,500 midwives has emphasized the need for the continuous supervision of TBAs. The new supervision system features technical supervision at the health centre/satellite; monitoring and replenishment of TBA supplies at the posyandu where the TBA resides; and motivation and support by local civic figures, especially in the prevention of neonatal tetanus. In addition, 17,000 TBA and midwifery kits have been provided, and the new "mother awareness" education programme has delivered messages similar to Facts for Life to 850,000 pregnant and lactating women. The programme focused on rural women and aimed to improve self-care during pregnancy, identify high-risk pregnancies, promote birth spacing and help mothers to improve infant care during the neonatal period.

17. The network of 80,000 family nutrition improvement programme weighing posts, which was in place when the posyandu strategy was adopted in the mid-1980s, provided the institutional foundation for the rapid development and expansion of the posyandu system. Faced with severe economic constraints, the Government took several steps that strengthened the nutrition programme. It continued strong financial and organizational support for the family nutrition improvement

programme/posyandu, reorganized the provincial health bureaux to improve their efficiency and co-ordination and intensified co-ordination of donor assistance. A nutrition assistance post is to be added to each puskesma (sub-district community health centre) as funding permits. UNICEF provided weighing scales, growth charts, vitamin A capsules and other supplies. In addition, UNICEF supported training or retraining in child growth monitoring and basic nutrition education for more than 1.5 million mostly female volunteer workers who staff posyandus.

18. The IDD control project has focused on strengthening monitoring and evaluation and supporting information, education and communication (IEC) activities of the programme, the most significant of which has been the integration of IDD control messages on the benefits of iodized salt into the community education component of the family nutrition improvement programme. These messages are disseminated through all 217,000 programme service posts. This step supports the government decision in 1985 to expand a ban on the sale of non-iodated salt from 15 to all 27 provinces. However, the production and sale of non-iodated salt and quality control of iodated salt on the market remain significant problems to be tackled in the next country programme.

Water and environmental sanitation

19. In the selected rural and urban areas receiving government/UNICEF co-operation, 60 per cent of the population now have access to clean water and 23 per cent to sanitary latrines, against the target of 67 per cent and 30 per cent, respectively. The shortfalls are due mainly to less than expected supplementary funding. UNICEF co-operation in the five selected provinces has not been reduced. However, some UNICEF activities that support the national programme have not been carried out (i.e., training, health education and water quality control). Meanwhile, the Government has begun an overall review of the rural water supply and sanitation projects, with support from the Asian Development Bank (AsDB). Government/UNICEF co-operation has strengthened research and monitoring activities, including an evaluation of the national presidential instruction programme. The results of project adjustments have been encouraging and included more community participation and responsibility for financing, planning, installing and maintaining water and sanitation facilities. In addition, an improved, standardized shallow hand-pump has been introduced nation-wide. Against this backdrop, knowledge, attitude and practice (KAP) surveys were conducted to help to develop health education materials based on community needs.

20. UNICEF paved the way for wider community participation through support for 9,700 village planning meetings. Volunteer caretakers appointed for each water facility were trained and provided with technical manuals, simple tools and spare parts for repair and maintenance. About 5,200 community volunteers were trained as community educators in the prevention of environmental pollution, hygiene, the proper use of water and the safe disposal of human excreta. Almost one half of the volunteers are women.

21. UNICEF supported the construction of 11,730 shallow wells, 2,970 deep wells, 1,290 rain collection tanks, 125 gravity-flow piped water systems and 159 spring protection systems, which benefited more than 1.75 million people. UNICEF also

supported the installation of 35,500 family latrines, 98 multiple latrines and 203 school latrines serving about 400,000 persons.

Community development and basic services

22. Local governments in the 5 provinces, 16 districts and 7 municipalities selected for intensive UNICEF assistance gave high priority to CSD and to the convergent delivery of basic services. Some 120 sectoral officials from the 16 targeted districts were trained to play more effective roles as members of district teams for planning, implementing and monitoring the delivery of basic services. In addition, 180 community block grants helped to meet the basic needs of low-income families by supporting activities such as livestock rearing, home gardening and small water and sanitation projects. In selected cities, 140 officers and 240 key sub-district personnel from health, education and other city service agencies received training in planning and managing urban basic services. Formal and informal community leaders from 98 selected low-income neighbourhoods were trained to formulate and manage 518 block grant proposals for water supply, group toilets, garbage disposal, kindergartens and child-care activities.

23. Community development programme activities complemented area services in the five selected provinces by supporting training and more intensive supervision. Almost 190,000 village development volunteers, more than 18,000 village heads and 12,500 supervisors of village development volunteers were trained in techniques for mobilizing community participation. A new district training and management system package was developed to streamline community development activities for community block grants and posyandu.

Education

24. UNICEF supported income-generating activities for more than 35,000 illiterate women through the non-formal education programme. This programme pioneered the development of a system whereby credit for income-earning activities is provided through the commercial banking system. The combination of income-generating and literacy activities has lowered the drop-out rate from the literacy programme and increased the participation of poor women. UNICEF also supported the basic literacy component of the programme which from 1985 to 1989 reached nearly 600,000 learners, two thirds of them women, in the areas selected for intensive UNICEF assistance. The completion of the first five books in the basic literacy programme is a prerequisite for participation in UNICEF-supported income-generating activities. This has helped significantly to improve overall programme performance. About 1,000 village reading corners were also established to reinforce the reading and writing abilities of new learners.

Programme monitoring

25. One of the priorities of past government/UNICEF co-operation (1984-1989) was to strengthen monitoring and supervision as tools for increasing coverage and improving the quality of basic services. The immunization programme introduced a local area monitoring methodology at sub-district (health centre) and district levels to identify specific local constraints to increased EPI coverage. This

monitoring methodology is being adapted for use by the maternal and neonatal care and family nutrition improvement programmes. Reviews and evaluations of several sectoral programmes have indicated a need for improved monitoring of training by district and municipal governments to increase its effectiveness. Intensive monitoring and follow-up is especially crucial for family nutrition improvement programme volunteers who staff the posyandus.

26. Government/UNICEF co-operation during the current country programme has (a) developed a computerized data base on children and women with more than 3,000 entries and a preliminary edition of a Thesaurus on Women in Development for Association of South-East Asian Nations (ASEAN) countries; (b) published abstracts and bibliographies on children and women; and (c) trained information providers and users in information management skills in subjects relevant to CSD.

RECOMMENDED PROGRAMME CO-OPERATION, 1990-1995

Recommended general resources: $62,450,000
Supplementary funds: $32,200,000

Recommended programme co-operation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Basic child and maternal health	16 501	4 495	20 996
Nutrition	11 471	16 175	27 646
Water and environment sanitation	10 780	8 500	19 280
Community development and poverty alleviation	6 707	-	6 707
Education	5 409	-	5 409
Advocacy, social mobilization and country programme support services	5 712	3 030	8 742
Planning and project support	1 320	-	1 320
Unallocated reserve	4 550	-	4 550
Total	62 450	32 200	94 650

a/ The breakdown for estimated yearly expenditues is given in table 2.

b/ In addition, there are also funded supplementary funding projects shown in table 2.

Programme preparation process

27. The Government commitment to CSD during its fourth national development plan of 1984-1989 led to the launching of several strategic initiatives that continued during the 1989-1994 development plan and helped to set the strategic and programme framework for 1990-1995 government/UNICEF co-operation.

28. This country programme was developed in line with the UNICEF medium-term plan, UNICEF strategies for children in the 1990s and the fifth national development plan, under the co-ordination of the National Development Planning Agency and with the participation of all relevant sectoral departments. Eight sectoral task forces for basic maternal and child health (MCH), nutrition, water and environmental sanitation, community development, area services, urban services, education and country programme support services helped to prepare the situation analysis of women and children in Indonesia, a review of government/UNICEF programme co-operation during 1985-1989, a country programme strategy and a five-year master plan of operations. These task forces were also used to prepare the 1985-1989 programme. They remained active during the last country programme and were therefore familiar with UNICEF priorities and in a good position to identify and incorporate lessons learned into the new country programme. Poverty-related indicators were used to identify disadvantaged districts and cities for intensive assistance. Other multilateral donors, bilateral agencies and international NGOs were also consulted on future CSD co-operation.

29. The objectives of the country programme are: (a) to reduce IMR to fewer than 50 deaths per 1,000 live births; (b) to reduce MMR from 450 to 340 or less per 100,000 live births; (c) to reduce total moderate and severe malnutrition by 12 per cent nationally and 20 per cent in high-risk areas; (d) to provide clean water supply in selected rural areas; (e) to achieve literacy rates of not less than 90 per cent for both sexes aged 10 years and above in the selected areas; and (f) to sustain universal primary education (over 95 per cent enrolment).

30. The Government has identified five leading strategies for achieving the country programme objectives: (a) increasing community participation in planning, management and support, with an emphasis on strengthening and expanding women's participation; (b) human resource development, i.e., improving the general health and nutritional status of the population, eradicating illiteracy and raising the average level of education, upgrading and broadening employment skills; (c) poverty alleviation, emphasizing not only improvement in the economic status of the poor, but also assuring that disadvantaged areas and population groups receive high priority in the delivery of basic services. Income-generating activities linked with literacy will be given high priority, as illiteracy is both an indicator of poverty and a factor in its perpetuation; (d) increased attention to budgetary support for operations and maintenance to sustain the programme and improve the quality of facilities and services; and (e) developing and strengthening the infrastrucuture to support and reinforce programme expansion.

31. None of those strategies is new to Indonesia, but establishing a limited number of priority strategies should help to focus efforts of the Government and donor agencies to achieve common goals. These strategies are also integral to the country programme objectives.

32. The country programme will support EPI and all nutrition activities nation-wide, and it will assist the child survival project with religious NGOs in 13 densely populated provinces. Other UNICEF assistance will be concentrated mainly in 17 rural districts of four provinces (West Java, South Sulawesi, West Nusa Tenggara and East Nusa Tenggara) and in the low-income neighbourhoods of 10 cities (Bandung, Surahaya, Semarang, Probolinggo, Pasuruan, Medan, Palembang, Padang, Pontianak and Banjirmasin). However, to extend the reach of government poverty alleviation efforts, other specially disadvantaged areas may be added to this group by mutual agreement between the Government and UNICEF.

33. The 17 selected districts have a combined population of more than 12 million, including 1.9 million children under five years old. About 3.2 million people, of whom more than 400,000 are under five years old, live in low-income urban neighbourhoods.

34. The country programme consists of six components. Three of these (basic MCH, nutrition and water supply and environmental sanitation) are core services that have a direct impact on infant, child and maternal morbidity and mortality. The three remaining components are support activities, including community development and poverty alleviation projects in education, advocacy and social mobilization.

Basic maternal and child health

35. This component consists of five projects: EPI, CDD, maternal and neonatal health, ARI and urban primary health care (PHC).

Expanded programme on immunization

36. Indonesia expects to achieve 80 per cent EPI coverage nation-wide by the end of 1990, and UCI in every province by 1994. National coverage for pregnant women with two doses of tetanus toxoid is also expected to reach at least 80 per cent by 1994. The expansion of tetanus toxoid coverage to those who leave school after grade 6 and marriage licence applicants opens the way for achieving five doses for all women during their reproductive lifetime. It is important for the EPI project to establish conditions for sustaining higher coverage levels. One of the main strategies for reinforcing and consolidating gains in immunization will be the dissemination of information similar to Facts for Life to generate and strengthen demand for services. Intensified promotion and support by local organizations such as the family welfare movement and village development councils will be major factors in this effort.

37. EPI management will be strengthened through the training of 4,000 health centre doctors as trainers for immunization staff, 6,000 vaccinators in EPI delivery and 450 logistics and cold-chain personnel in tasks related to vaccine distribution and cold-chain maintenance and repair. Sub-district, district and provincial cold storage and refrigeration facilities will be upgraded or replaced as needed. The present policy of using one sterile needle and one sterile syringe for each injection will be continued and strengthened in all provinces. Indonesia is self-sufficient in all bacterial vaccines, and the Government is seriously considering the production of viral vaccines.

Control of diarrhoeal diseases

38. The CDD programme is a national one, as diarrhoea control is one of the main components of the posyandu system. UNICEF co-operation will focus on the selected areas (17 districts and 10 cities) and will give priority to case management and community education about the causes of diarrhoeal diseases and the importance of proper treatment to prevent serious illness and childhood deaths due to diarrhoeal dehydration. Assistance will be provided for about 3,500 district and sub-district health personnel and more than 41,000 volunteer co-ordinators from posyandu in the selected districts and cities. Attention will also be given to cultural attitudes towards diarrhoeal diseases that often influence home treatment and referral practices. A government/WHO/UNICEF/United States Agency for International Development (USAID) programme review found that 55 per cent of mothers could mix ORS, but actual ORT use at home is estimated by the Department of Health at only 40 per cent.

39. UNICEF will also support the accelerated development and application of techniques for effective community education through mass media and other channels. Subject to the availability of supplementary funding, training and communication activities will be carried out in all districts of the selected provinces and possibly extended to other disadvantaged areas. Lessons learned through experience in these areas will be applied in the national CDD programme. To support the above service delivery improvements and information dissemination efforts, UNICEF co-operation will supply at least 15 million sachets of ORS annually for distribution through the posyandus under the national CDD programme.

Maternal and neonatal health care

40. UNICEF will support a package of activities to promote safe childbirth and maternal and neonatal health. Education in "mother awareness" is one component of this package, which includes organized group discussions among mothers, married women and prospective brides, assisted by specially trained posyandu volunteers, with important back-up and support from TBAs. Approximately 7.2 million women in the four selected provinces will be reached with information on self-care during pregnancy, factors associated with high-risk delivery, including frequent pregnancy and short inter-birth intervals, and appropriate post-natal practices to ensure the health of mothers and new-born infants. The importance of timely referral of high-risk cases to a qualified midwife or doctor will be emphasized. The Government and UNICEF are looking for an affordable means of providing referral services for difficult maternity cases, and are looking for other partners to assist in this endeavour. UNICEF will assist the development, reproduction and distribution of communication materials used in the "mother awareness" group sessions and the management support training for 170 health centre doctors and midwives. More than 43,000 female posyandu volunteers will also be trained to organize and lead the discussion groups.

41. The second component of this project is designed to upgrade the quality of health services for infants and pregnant and lactating women in the selected areas and cities. Training for about 650 midwives will emphasize preventing nutritional anaemia and eliminating missed opportunities to immunize pregnant and young

unmarried women with tetanus toxoid during routine contacts with the health delivery system. TBA supervision by health centre midwives will be strengthened to ensure better and more uniform delivery practices, encourage referral of difficult cases to district hospitals and involve TBAs more actively in promoting tetanus toxoid immunization to reduce the incidence of neonatal tetanus. Subject to the availability of supplementary funds, the maternal and neonatal project will be expanded to cover all districts in the four selected provinces and may be extended to other especially disadvantaged areas.

Acute respiratory infections

42. According to the 1986 national household health survey, ARI accounts for about 15 per cent of the country's IMR and over 40 per cent of all infant and child morbidity. The ARI project will be implemented in those rural and urban areas selected for intensive government/UNICEF co-operation. A sub-district health centre staff of 3,500 and 46,500 posyandu volunteers will be trained in standard treatment techniques and case management for mild, moderate and severe ARI. Each of these case categories will receive appropriate treatment at each administrative level: in the home (by cadres); at health centres; and in hospitals. Existing preventive measures (including immunization, breast-feeding, nutrition education and ARI prevention education for parents) will be expanded through all available channels in order to complement the treatment-based approach. The monitoring indicators will be annual numbers and percentages of infants covered with a full course of dipthteria/pertussis/tetanus and measles vaccinations, health centre and hospital ARI incidence and under-five mortality figures. Project data will be compared with data for health centres in the seven WHO-supported pilot projects currently under way in selected sub-districts in Java, Sumatera and West Nusa Tenggara.

43. A systematic strategy for dealing with ARI on a national scale is pending owing to the relatively recent initiative in tackling this serious problem and the complexity of its solution. Research and advocacy for a national programme are, therefore, top priorities.

Urban primary health care

44. As part of the effort to strengthen the capacity of municipal governments in the 10 selected cities to promote CSD, this project will give special attention to the achievement of UCI. Municipal governments will also be assisted in mass media promotion of ORT and community education in Facts for Life topics, stressing the importance of at least four antenatal examinations, iron supplements to prevent nutritional anaemia and tetanus toxoid immunization.

Nutrition

45. The nutrition component of the country programme consists of the family nutrition improvement programme, the control of IDD and food and nutrition surveillance system projects.

Family nutrition improvement programme

46. This programme offers child growth monitoring, nutritional first aid and education for mothers. It was selected, as a service directly affecting infant, child and maternal mortality, to be part of an integrated strategy of service delivery at the village through the posyandu. Growth monitoring posts provided the framework for the expansion of posyandu. Basic nutrition services are now accessible to more than 80 per cent of Indonesia's 23 million children under five years old because of the rapid expansion of posyandus. However, only about 50 per cent of the children with access attend the weighing post on a regular monthly basis. UNICEF co-operation will raise public awareness to encourage higher, regular attendance of children and mothers at the posyandu. Support will also be provided to new and existing posts for essential supplies and equipment, staff training and strengthening of organizational infrastructure. More than 17,000 new posyandus will be established, bringing basic health and nutrition services within reach of nearly all Indonesian families. Weighing scales, growth charts, vitamin A and iron folate will be provided for more than 145,000 posts, 86,000 new volunteers will be trained and an additional 1.5 million volunteers will be retrained. Particular efforts will be made to upgrade volunteers' knowledge of growth faltering in an attempt to improve the effectiveness of maternal counselling. Greater attention to dietary sources of vitamin A and iron will be given during volunteer training to promote, through counselling at posyandu sessions, a sustainable and long-term solution to the problem of vitamin A deficiency and iron deficiency anaemia.

47. Support services will be strengthened through a UNICEF-assisted training programme. Nearly 9,000 district and sub-district health personnel will receive refresher training to improve technical and managerial support, and almost 2,000 district family planning supervisors will be trained or retrained to strengthen programme monitoring and IEC activities. The Department of Agriculture will train 180 staff from provincial agriculture information centres and 7,500 extension trainers, supervisors and field workers, who will promote and support family food production and the consumption of nutritious foods. Another 600 district staff members will be trained in food and nutrition policy planning, and more than 71,000 members of women farmers' groups will be trained in basic nutrition education and improved production techniques for family gardens. The Department of Religious Affairs will train more than 6,000 community religious leaders to link basic religious principles with Facts for Life messages and thus promote CSD objectives through religious channels. Some 8,000 sub-district staff of the Department will receive refresher training to improve the quality of supervision, monitoring and guidance of village-level religious activities designed to stimulate participation in posyandu services. Finally, local government management of nutrition improvement activities will be strengthened through 21 field-based training exercises in growth monitoring conducted by the Department of Home Affairs. Sub-district and village heads and their staff, as well as the technical supervisors of village development cadres, will participate in these exercises. Substantial supplementary funding will be required to maintain full national coverage of this programme.

Control of iodine deficiency disorders control

48. A recent evaluation found a significant reduction in the incidence of goitre in 10 of the 12 provinces studied. While this undoubtedly reflects progress through lipiodol injection and salt iodation activities, the lack of public understanding of the consequences of iodine deficiency and the importance of using iodized salt is still a serious constraint. Therefore, UNICEF assistance will concentrate mainly on developing and implementing community education to raise public awareness of the serious consequences of iodine deficiency, particularly among pregnant women and young children, and to encourage the use of iodized salt. In addition, the project will provide assistance for developing and testing iodine supplementation techniques that are more cost-effective and easier to administer than the iodized oil injection programme currently being implemented. UNICEF will also support improved monitoring and quality control of iodine-fortified salt processing and marketing.

Food and nutrition surveillance system

49. This project aims to consolidate available statistical information in areas such as food production, dietary habits and nutritional intake, deficiencies in protein, calories and micronutrients and the incidence of low birth weight. It will also develop a system of data storage, retrieval and analysis to facilitate more effective and systematic use of the information for planning and monitoring purposes. The project will support the development and testing of cost-effective techniques for measuring or indirectly estimating critical nutritional variables, such as the incidence of vitamin A deficiency.

Water and environmental sanitation

50. Government/UNICEF co-operation in 17 districts and 10 cities will aim to revitalize national water and sanitation programmes, intensifying community participation and the maintenance of facilities. This will support government efforts to reach low-income families as part of broader poverty alleviation objectives. This pioneering effort will also strengthen programme linkages between these and other P.C components, including CDD and the protection of children's environment. In the national programme, UNICEF assistance will be provided for the development, production and distribution of promotional and community education materials, training curricula and supporting manuals and learning aids; training of trainers for maintenance of water and sanitation facilities; surveillance of water quality; improvement of water and sanitation data systems; and monitoring and evaluation.

51. Government/UNICEF co-operation will be co-ordinated with other donor-supported water and environmental sanitation projects in order to share experiences, ensure standardized equipment and supplies and avoid duplicating coverage areas.

52. About 1,600 villages will be covered through UNICEF assistance in the selected areas. About 1.9 million people living in these areas will be reached with clean water, and an estimated 1.8 million will receive sanitary latrine facilities. More than 12,000 new hand-pumps, spring protection and rain-water collection facilities

will be installed, in addition to 75 rural gravity-flow piped systems and 2,000 public taps in urban areas. Rehabilitation and reconstruction of inoperative and sub-standard water supply installations will account for more than 10,000 additional units. User groups will be organized in each village to help to plan, install, maintain and operate these facilities. Programme support will also include Facts for Life training for approximately 35,000 community volunteers, at least half of them women, stressing the importance of clean water, sanitary excreta disposal, personal and food hygiene and environmental protection and conservation. This training will also include technical instruction in facility maintenance so that trainees can serve as caretakers in their home communities. Over 500 government staff and 420 volunteers and NGO personnel will be trained in drilling, logistics, installation and maintenance of water facilities.

53. Installation of sanitary latrines and household waste water disposal facilities will be supported by the programme in the selected districts and cities. The construction of sanitation and water facilities will be co-ordinated to reach target groups simultaneously whenever possible. Priority will be given to family latrines, where adequate space is available, and to the neediest segments of the target population. Multiple latrines will be installed in densely populated urban areas where family units are not feasible. The construction of about 300 primary school latrines, in combination with water facilities, will also be supported. One of the principles applied in the construction of both water and sanitation facilities is that there should be no negative environmental impact.

Community development and poverty alleviation

54. This component of the country programme consists of several closely interrelated projects aimed at strengthening the capacity of the subnational governments and administrations (i.e., in the selected provinces, districts and municipalities and their constituent sub-districts and villages) to plan, co-ordinate, manage and monitor the delivery of basic services for children and women. A related objective is to improve communication and information exchange among these levels and between them and the central sectoral departments. These objectives will be achieved through a combination of formal and on-the-job training for planners and implementers; orientations for provincial, district and municipality legislators, government officials and NGO leaders to raise awareness of CSD issues and elicit support for programme efforts; real-life exercises in planning, management, supervision, target identification and problem solving; and development of a management information system to promote the collection and more effective use of relevant, reliable programme data. In all, 380 province and district officials, 170 sub-district staff and 9,000 village development council volunteers will participate in these training and capacity-building exercises.

55. Particular attention will be given to ways of identifying the neediest localities and groups and the most practical and effective means of reaching them with basic services. A small block grants programme administered through the community development/area and urban component provides a potentially effective mechanism for reaching unreached and underserved communities and disadvantaged families.

56. The urban poverty alleviation support project will identify 272 disadvantaged neighbourhoods in the 10 selected cities for intensified basic services delivery, special block grants projects and community action activities. (In the cities of Surabaya, Bandung and Semarang, where financial and managerial capacity is already relatively well developed, all disadvantaged neighbourhoods, rather than selected ones, will be included in the UNICEF programme.) CSD advocacy and programme training activities will reach approximately 150 city officials, 1,800 sub-district officials and nearly 3,000 community leaders.

Education

57. An estimated 300,000 illiterates and primary school drop-outs in approximately 1,500 villages in the selected districts and cities are the target population for co-operation in non-formal education. Basic literacy activities are funded by the Government non-formal education programme, and UNICEF assistance will support the development, production and distribution of supplementary learning materials focusing on Facts for Life and related CSD topics. To improve access to reading materials in the 1,500 villages, village reading corners will be established in each and stocked with approximately 300 general titles and 40 specially produced publications on CSD and occupational topics. The UNICEF programme will also support combined literacy and small-scale income-generating activities for 75,000 poor women. UNICEF funds are loaned to groups from 5 to 10 women as capital for various income-generating activities, and are recycled for use by other groups as the initial loans are repaid. The funds are administered by a commercial bank. This project was developed during the 1985-1989 co-operative programme. Priority will be given to improving management effectiveness, increasing the participation of poor women, developing a more efficient monitoring system and improving the quality of CSD education in the non-formal literacy education package.

58. Islamic educational institutions will provide a new channel for reaching more poor families with information similar to Facts for Life. Approximately 3,000 teachers and other personnel from 384 Islamic education institutions will receive basic training in topics such as ORT, safe motherhood and child growth monitoring, as well as in techniques for reaching and motivating community members through religious activities. This project will reach an estimated 135,000 people in the selected areas, of whom about 60 per cent are women.

59. The Department of Education and Culture is working through the Asia-Pacific Programme of Education for All Task Force to prepare Indonesia's contributions to the World Conference on Education for All. It is expected that the Government will make substantive contributions to the regional meeting through its country presentation on education for all policies and programmes in the fifth national development plan, and its comments on the background paper, framework for action and Education for All Declaration. An inter-agency forum for consultation on the World Conference will be held with the United Nations Development Programme (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Bank and, in a somewhat less intensive manner, with other concerned agencies such as AsDB.

Advocacy and social mobilization

60. In recent years, Indonesia has made great progress in reducing infant and child mortality, expanding immunization coverage and increasing access to basic health services. Much of this progress is the result of government commitment, but another key to success has been the mobilization of the country's citizens to promote and support CSD. Government/UNICEF co-operation will continue to give high priority to advocacy, public information and social mobilization to maintain the momentum that has been achieved and to encourage even greater progress in the future. UNICEF co-operation will support the Office of the Minister Co-ordinator for People's Welfare to strengthen national, provincial and district/municipal assessments of the situation of children, and it will advocate with relevant government agencies and NGOs for improved intersectoral policies and programmes for children. The Office of the State Minister for the Role of Women will promote the increased participation of women in social development programmes and activities, especially to improve CSD. Both ministerial offices will also work to create greater public awareness of and support for safe motherhood and a reduction in MMR, as well as to strengthen the capacity of low-income mothers to promote the early psychological and physical development of their children.

61. Support for social mobilization of women will help women to play a stronger role in all aspects of CSD and protection. The family welfare movement will be assisted to implement its neighbourhood family welfare system (dasa wisma), in which one female volunteer is responsible for motivating and counselling 10 to 20 families in the 17 selected districts and 10 cities. Higher-quality training and supervision for 4,000 sub-district organizers and 31,000 village volunteers in the selected areas will be provided to help the family welfare movement to accelerate its nation-wide efforts to promote family participation and support for integrated service posts and community education. In a related effort, the child survival project, working with the women's branches of 17 major religious NGOs, will be expanded from 11 to 13 provinces. These provinces are home to 80 per cent of Indonesia's under-five population. Some 6,000 new volunteer motivators will be trained, bringing the total motivator force to more than 24,000 women. During the 1985-1989 co-operation, the child survival project focused specifically on immunization and ORT. During the next five years, its scope of motivational activities will be expanded to cover other CSD topics such as child growth monitoring, the prevention of visual impairments and other consequences of vitamin A deficiency and improved care for pregnant women.

Unallocated funds

62. Unallocated reserves allow future response to unforeseen CSD needs and opportunities in areas such as antenatal care, community development, early childhood education, CDD and other projects.

Convention on the Rights of the Child

63. The Government strongly supports efforts within the international community to adopt and ratify the Convention on the Rights of the Child. In May 1989, the Minister Co-ordinator of People's Welfare hosted an informal consultation for ASEAN

member States which discussed issues related to child welfare and rights and possible joint ASEAN activities in the context of the Convention. Indonesia has begun a review of its national legislation to determine consistency with the principles contained in the Convention, and is studying children's issues raised in the Convention debate. National Children's Day celebrations and other public information activities will be used to promote support for the Convention throughout the programme cycle.

Co-operation with United Nations and other bilateral agencies

64. UNICEF assistance has been provided in conjunction with a number of bilateral and multilateral donor organizations. These include WHO, the World Bank and the Governments of Australia, New Zealand, Switzerland and the United States. Every effort is made to ensure that UNICEF inputs are closely co-ordinated with assistance from other donors. Successful donor collaboration, with co-ordination by the Government, includes assistance for UCI, accelerated posyandu establishment, wider coverage of non-formal literacy education and increased social mobilization for the promotion of ORT. Important exchanges were made with UNDP, WHO, the World Bank, the United Nations Population Fund, the World Food Programme and UNESCO during the preparation of the proposed country programme.

65. UNICEF plans to encourage the Government of Indonesia to strengthen co-ordination of donor assistance pertaining to poverty alleviation, CDD policy development, the promotion of ORT, and maternal and neonatal health care. Concerned donors include UNICEF, WHO, USAID, the World Bank and others.

INDONESIA

Basic data: 1988 and earlier years

Under-five mortality rate	100x/	(1988)	UNICEF country classification: High U5MR
Infant mortality rate	75x/	(1988)	High IMR
GNP per capita	$450	(1987)	Low GNP
Total population	175 million	(1988)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1988
Births	(thousands)	4866	5091	4927	4822
Infant deaths (under 1)	(thousands)	579	509	443	323
Under-five deaths	(thousands)	910	738	621	468
Under-five mortality rate (per 1,000 live births)		187	145	126	100x/
Infant mortality rate (under 1) (per 1,000 live births)		119	100	90	75x/

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1987)	Moderate & severe	..	51
	Severe	..	1
Babies with low birth weight (%, 1980)		14	..
Children completing primary level (% of first grade, 1986)		..	80

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1985)		98*/97*/83*	98*/97*/76*
Prevalence of wasting (%, 1978/1986)		17	11*
Prevalence of stunting (%, 1978/1986)		62*	46*
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)		113	116
Food production per capita index (Index 1979-1981=100, 1980/1988)		101	119
Household expenditure (% of total income, 1980/1987)	All food/cereals	69*/24*	61*/17*

HEALTH INDICATORS		About 1980	Most recent
ORS use rate (%, 1986-1987)			55
Access to health services (% of population, 1985)	Total	..	80*
	Urban/rural	.. /..	../..
Access to safe water (% of population, 1980/1986)	Total	30*	38
	Urban/rural	42*/27*	43/36
Access to adequate sanitation (% of population, 1980/1986)	Total	23	37
	Urban/rural	29/21	33/38
Births attended by trained personnel (%, 1986)		..	54*
Maternal mortality rate (per 100,000 live births, 1986)		..	450

Immunization		1981	1985	1987	1988
One-year-olds (%) immunized against:	Tuberculosis	55	68	82	86
	DPT	(.)	16	69	75
	Polio	(.)	14	70	78
	Measles	..	16	61	68
Pregnant women (%) immunized against	Tetanus	10	26	33	40

INDONESIA

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	100x/	(1988)	High U5MR
Infant mortality rate	75x/	(1988)	High IMR
GNP per capita	$450	(1987)	Low GNP

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	107/88	118/98
(%, 1980/1987)	Male	115/93	120/99
	Female	100/83	115/97
Secondary enrolment ratio (gross/net)	Total	29/..	46/37
(%, 1980/1987)	Male	35/..	../..
	Female	23/..	../..
Adult literacy rate, 15 years & older	Total	54	74
(%, 1970/1985)	Male/female	66/42	83/65
Radio/television sets			
(per 1,000 population, 1980/1987)		99/20	145/40

DEMOGRAPHIC INDICATORS		1970	1980	1985	1988	2000**
Total population	(millions)	120.3	151.0	166.5	175.0	208.3
Population aged 0-15 years	(millions)	..	65.2	68.2	67.9	65.6
Population aged 0-4 years	(millions)	..	22.4	22.2	21.4	20.7
Urban population (% of total)		17	22	25	27	36
Life expectancy at birth (years)	Total	46	52	55	56	62
	Male/female	46/47	50/53	53/56	55/58	61/64
Total fertility rate		5.3	4.4	3.7	3.2	2.4
Crude birth rate (per 1,000 population)		40	34	30	27	21
Crude death rate (per 1,000 population)		18	14	12	11	9

		About 1980	Most recent
Contraceptive prevalence rate		..	48
(%, 1987)			
Population annual growth rate	Total	2.3	1.8
(%, 1965-1980/1980-1988)	Urban	4.7	4.5

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		5.2	1.7
(%, 1965-1980/1980-1987)			
Inflation rate (%, 1965-1980/1980-1987)		34	9
Population in absolute poverty	Urban/rural	29*/28*	20*/16*
(%, 1980/1987)			
Household income share	Top 20%/bottom 40%	42*/20*	42*/21*
(%, 1980/1987)			
Government expenditure	Health/education	2 / 8	1 / 9
(% of total expenditure, 1980/1987)	Defence	13	9
Household expenditure	Health/education	.. /..	2 / 4
(% of total income, 1980-1985)			
Official development assistance:	US$ millions	950	1245
(1980/1987)	As % of GNP	1	2
Debt service			
(% of goods & services exports, 1980/1987)		7	28

x/ Provisional.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 1. BREAKDOWN OF ACTUAL EXPENDITURE FOR GENERAL RESOURCES AND SUPPLEMENTARY FUNDING UNDER PREVIOUS CO-OPERATION PERIOD, 1985-1989

(Thousands of United States dollars)

COUNTRY: INDONESIA
LATEST BOARD APPROVAL: 1985
GENERAL RESOURCES: $50,000,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	SF	GR	SF	GR	SF	GR	SF	GR	SF	Total
Health	4528	2929	1420	518	501		1112	348	7562	3795	11357
Water supply and sanitation	3505	657	171	23	1696		1233		6604	680	7284
Nutrition	3016	4825	1227	2828	720		854	933	5818	8586	14404
Education	98		264		116		992		1470		1470
Community organization and development	111		952		1031		2844		4938		4938
Young child development							5		5		5
Women-centred programme	33		592		87		1664		2376		2376
Emergency				30		29		1040		1099	1099
Planning and project support	91	87	378	48	1990	75	1938	1358	4397	1568	5965
Freight	455	162							455	162	617
GRAND TOTAL	11837	8660	5004	3447	6142	104	10641	3678	33623	15890	49513

GR = General resources.
SF = Supplementary funding.

TABLE 2. PLANNED EXPENDITURE FOR GENERAL RESOURCES, NEW SUPPLEMENTARY FUNDING AND FUNDED SUPPLEMENTARY FUNDING

(Thousands of United States dollars)

Country: INDONESIA Period covered: 1991-1995	Funding status	1990	1991	1992	1993	1994	1995	Total
Health								
Immunization	GR	2121	1485	1505	1034	1532	1227	8905
	FSF	1220	1220	1339				3779
Control of diarrhoeal diseases	GR	346	522	707	500	500	514	3088
	NSF		375	290	390	422	472	1949
Other health	GR	933	993	788	666	571	558	4508
	FSF	39						39
	NSF		375	510	560	489	612	2546
Subtotal, health	GR	3400	3000	3000	2200	2602	2299	16501
	FSF	1259	1220	1339				3818
	NSF		750	800	950	911	1084	4495
Water supply and sanitation	GR	1680	1700	1700	1700	2000	2000	10780
	FSF	542						542
	NSF		1720	1800	1666	1664	1650	8500
Nutrition	GR	1920	2000	2000	2000	1669	1882	11471
	FSF	4281						4281
	NSF		3146	2958	3426	2941	3704	16175
Education	GR	791	800	900	960	948	1010	5409
Community organization and development	GR	1423	1000	900	1370	1000	1014	6707
	FSF	822						822
Advocacy	GR	1236	730	730	1000	1001	1015	5712
	FSF	534						534
	NSF		945	830	645	325	285	3030
Planning and project support	GR		260	260	260	270	270	1320
Unallocated	GR		910	910	910	910	910	4550
TOTAL	GR	10450	10400	10400	10400	10400	10400	62450
	FSF	7438	1220	1339				9997
	NSF		6561	6388	6687	5841	6723	32200
GRAND TOTAL		17888	18181	18127	17087	16241	17123	104647

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

TABLE 3. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: INDONESIA	Number of posts	1990-1991 amount (Thousands of US dollars)
FINANCED FROM 1990-1991 APPROVED BUDGET:		
International Professional established posts	6	1218
Local national Professional and General Service established posts	12	2081
Operating costs		1373
Total	18	4671
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	12	2244
Supplementary funds		
Local national Professional and General Service project posts		
General resources	35	1788
Supplementary funds		
Total	47	4032

a/ For information source, see 1990 post authorization table, revised October 1989.

Annex

SELECTED LIST OF STUDIES AND EVALUATIONS

1. "Situation analysis of children and women in Indonesia", Government of Indonesia/UNICEF, April 1989.

2. "Review of Government of Indonesia/UNICEF co-operation during 1985-1990", National Development Planning Agency and UNICEF, 1989.

3. "CDD/EPI programme review", Government of Indonesia/USAID/WHO/UNICEF, December 1986.

4. "Proceedings of a seminar on the 1986 household health survey", Department of Health, December 1987.

5. "Trial of Wavin hand-pump in Indonesia", Department of Health, September 1988.

6. "Regional indicators of child welfare 1986", Provincial Statistics Office and Provincial Planning Board, West Sumatera, December 1988.

UNITED
NATIONS

E

Economic and Social Council

Distr.
LIMITED

E/ICEF/1990/P/L.19
9 February 1990

ORIGINAL: ENGLISH

UNITED NATIONS CHILDREN'S FUND
Programme Committee
1990 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Cambodia

The Executive Director recommends that the Executive Board approve an amount of $2,500,000 from general resources, subject to the availability of funds, and an amount of $7,500,000 in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme of Cambodia for the period 1991.

* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme co-operation at the end of 1989, will be contained in the "Summary of 1990 recommendations for general resources and supplementary funding programmes" (E/ICEF/1990/P/L.1).

CONTENTS

Page

THE SITUATION OF CHILDREN AND WOMEN 3

PROGRAMME CO-OPERATION, 1988-1990 5

RECOMMENDED PROGRAMME CO-OPERATION, 1991 9

BASIC DATA 17

List of tables

1. Breakdown of actual expenditure for general resources and supplementary funding under previous co-operation period, 1989 19

2. Planned expenditure for general resources, new supplementary funding and funded supplementary funding 20

3. Staffing from budget and programme funds 21

THE SITUATION OF CHILDREN AND WOMEN

1. The situation of children and women in Cambodia must be seen in the context of the tragic decade of the 1970s. The war that engulfed the country early in the decade was followed by domestic policies that caused mass starvation and the destruction of social and economic infrastructure. Millions of people were displaced, and up to 2 million perished out of a total population of 8 million. The professional manpower of the country was decimated. The health and public education systems were destroyed with less than 10 per cent of doctors and only one quarter of the primary school teachers of the 1960s remaining by 1979. The institutional memory necessary to sustain and enhance social development had been dissipated. By 1980, the infant mortality rate (IMR) had risen to 211 per 1,000 live births and the under-five mortality rate (U5MR) was about 330 per 1,000 live births.

2. Today, Cambodian children and mothers continue to suffer from the impact of past events. The health situation of children improved during the 1980s, but the IMR of 127 per 1,000 live births and the U5MR of 199 per 1,000 live births, are among the highest in the world. High perinatal and neonatal mortality rates are attributed to unhygienic delivery practices which result in neonatal tetanus (in some areas accounting for at least 30 per cent of infant mortality), measles, diarrhoea, and acute respiratory infections (ARI). The principal causes of child morbidity are diarrhoeal diseases, protein-calorie malnutrition, ARI, typhoid, anaemia, tuberculosis, dysentery, dengue haemorrhagic fever and malaria. The majority of these health problems stem from poor environmental conditions, lack of knowledge about individual and public hygiene and the late or under-utilization of available preventive and curative services.

3. As a result of many years of conflict, the demographic structure has been dramatically altered. About 64 per cent of the adult population are women and 35 per cent of households are headed by women. The heavy economic responsibilities of women, especially those who are heads of families, together with the burden of large numbers of children (the fertility rate is 4.7), a physique already weakened by undernutrition and previous hardships, pose serious threats to women's health. It is believed that the high maternal mortality rate is due to complications from abortions and haemorrhage. Traditional birth attendants (TBAs) are responsible for 80 to 90 per cent of deliveries, and although they are experienced in childbirth delivery techniques, they lack skills in aseptic deliveries and antenatal monitoring.

4. In 1988, the Ministry of Health reported that 16 per cent of children under five years old were malnourished (under 80 per cent weight for height) and 3 per cent were severely malnourished. Chronic malnutrition, manifested in stunting, was found in 22 per cent of children in Phnom Penh and 32 per cent in other areas. Much child malnutrition can be attributed to subsistence agriculture and fluctuations in food supply, low levels of household income, inadequate feeding practices, high incidence of infectious diseases and maternal undernutrition. Low birth weight is estimated by one study in Phnom Penh at 17 per cent of births.

5. Food production and availability remain vulnerable to droughts and floods. Inadequate water supplies, poor irrigation, low seed stocks, insufficient agricultural inputs and implements, and manpower shortages are also major problems. The heavy population loss in the 1970s resulted in a heavy burden of the agricultural labour falling to women. Fish, livestock and secondary crop production contribute to family diets, but availability varies among regions. National capacity to ensure a constant and adequate food supply is hampered by the underdeveloped economy and financial infrastructure and by the poor roads and communications networks. Although recent changes and liberalization of economic policies have had a positive impact on the production of basic goods and commodities, many segments of the population have been left without access to the market and cash economies. Agricultural production is mainly based on rain-fed rice monocropping. Although the tradition of family food gardening is prevalent, the quantity and variety of food is usually inadequate to meet family needs and to provide families with a balanced diet.

6. Cambodia has the potential for considerable water resources, with abundant surface water and aquifers, and generally high levels of seasonal rainfall. However, the devastation of public utilities and water distribution systems in the 1970s continues to affect the supply of safe water. Only about 3 per cent of the population have access to safe drinking water. Diarrhoeal diseases caused by water-borne diseases and hygiene-related infections are linked to 40 per cent of deaths of children under five years of age. The lack of awareness about unsafe water and poor sanitation practices in homes, schools and public places constitute great health risks. Although some progress was made in the 1980s, environmental sanitation is extremely poor. The population of Phnom Penh has grown to over 800,000 without a concurrent restoration of sewage and waste disposal systems. A latrine building programme in rural areas was initiated, but it is hampered by traditional practices and a lack of understanding of the benefits of adequate sanitation.

7. From almost complete annihilation in the 1970s, the educational system has made a remarkable recovery due to the high priority attributed to this sector. A measure of achievement is that close to 90 per cent of school-age children are at school in grade one. A rapid expansion of the educational system has been achieved, but with an unfortunate compromise on quality and relevance and relatively high wastage rates.

8. Large numbers of teachers were trained very rapidly to compensate for the severe shortages, with teacher-training content and methodology suffering as a result. Moreover, materials for teacher training and for schoolchildren are highly insufficient. Since 1979, some 4,750 primary schools have been established with limited resources. Most of them are in a derelict condition and lack water, sanitation facilities and the most basic items to ensure proper functioning. Teacher-training institutes are in similarly poor conditions. Such deficiencies constrain education and compromise attempts to teach proper health and hygiene practices to pupils.

9. During the events of the 1970s, countless numbers of children died, were handicapped, orphaned or suffered a variety of difficulties, and many of them are

still exposed to conflict. Little information exists on the physical and mental consequences that have marked many children and women, and services designed to address these problems are inadequate.

10. Planning and programming for child survival and development (CSD) and other sectors would be greatly enhanced by increased statistical data, improvements in technical and managerial capacity and greater access to equipment and essential provisions.

11. The destruction of the 1970s presents major challenges to CSD and rapid educational expansion. Some progress has been made in re-establishing road and rail links, as well as in establishing radio, press and telecommunications services but the loss of equipment and professional personnel hamper the effective use of the mass media.

PROGRAMME CO-OPERATION, 1988-1990

12. UNICEF responded to the devastation of the 1970s with emergency assistance aimed at ensuring child and family survival and restoring basic education, primary health care (PHC) and safe water supplies. This phase lasted from October 1979 to December 1981. In a second phase, UNICEF assistance focused on the rehabilitation of the social services infrastructure through the provision of supplies and equipment, training, technical assistance and limited support for the production of drugs, school furniture and textbooks. For the past few years, UNICEF has supported a third phase which included efforts to develop longer-term and more comprehensive basic services approaches, with increasing emphasis on the qualitative aspects of CSD and enhancing the situation of women. There has also been an effort to promote a greater convergence of services in the 11 provinces of the centre and south around Phnom Penh, where some 74 per cent of the country's population live.

Health

Manpower development for primary health care

13. In 1988-1989, special support was provided to improve staff capacity in the management and planning of basic health services. Co-ordination with such non-governmental organizations (NGOs) as Coopération internationale pour le développement et la solidarité and Redd Barna (Norwegian Save the Children) was strengthened in order to improve implementation and monitoring at the field level. UNICEF supported short-term training in France for national-level health personnel in the fields of nutrition, public health and epidemiology. Other health personnel took correspondence courses organized jointly by the United States Centres for Disease Control and the International Children's Centre. UNICEF supported the central midwifery and nursing school to develop the training activities of the regional schools. UNICEF co-operated with the NGO Enfants du Cambodge in aspects of this work. A comprehensive study of the health services system was undertaken in order to establish a reliable information base for the development of the PHC system and for related training.

Maternal and child health

14. UNICEF recently supported the development of a comprehensive national programme of prenatal care, with technical expertise and material support to the Maternal and Child Health (MCH) Unit of the Ministry of Health provided by the Australian Save the Children Fund. An important aspect of the programme is the training of staff at all levels, including TBAs. Guidelines have been prepared outlining the functions of central and provincial authorities, as well as the commitments of external agencies. Other NGOs have indicated their interest in supporting provincial authorities for this programme in order to achieve national coverage.

15. The rehydration, immunization, nutrition and education (RINE) centres continue to provide services in 12 provinces. These centres located at the provincial and district levels under the direction of the MCH Unit of the Ministry of Health, were first established as a service delivery system. UNICEF provided support for drugs, training, the printing of training materials and supplementary feeding. Co-operation was also extended to the centres by NGOs such as World Vision International, the Mennonite Central Committees, the Japanese Volunteer Centre and Enfants du Cambodge, with whom activities were co-ordinated. However, concern has continued over the limited coverage of the RINE centres and the inadequate integration of their activities into the basic health services structure. These issues are the subject of consultations with the Government.

Immunization

16. Since it was launched in late 1986 UNICEF has supported the expanded programme on immunization (EPI) with the provision of equipment and supplies, training in vaccination techniques, cold-chain management and maintenance and social mobilization. Assistance was also provided for improving distribution and logistics. In 1989, coverage surveys were expanded to Phnom Penh and 12 other provinces. Preliminary surveys indicate that 70 per cent of children aged 12-23 months were fully immunized in these provinces, which together account for 75 per cent of the country's population. The immunization of women against tetanus was not integrated into EPI until 1987.

17. Relatively high child immunization coverage rates were reached through campaigns with mobile teams operating vaccination clinics in the villages. Routine epidemiological reporting and disease surveillance have been initiated and when completed will provide more reliable data on the impact of immunization. The results of a "missed opportunities" survey carried out in the National Paediatric Hospital of Phnom Penh reinforced the importance of providing immunization wherever consultation is available. It was decided to make immunization services available at district and provincial hospitals. EPI is the only national programme with outreach into the communities, and consideration is now being given to the possibility of integrating other MCH services with it.

Communicable disease control

18. UNICEF continued to support the malaria control programme through the training of personnel, the provision of laboratory supplies and expertise. UNICEF also

supported a vector control assessment in five key provinces through the provision of laboratory supplies, materials and transport. UNICEF continued to supply oral rehydration salts (ORS) (1.4 million sachets in 1989) for national distribution through the hospitals and health centres in all provinces. The preparation of home-made solutions was taught at district centres.

Essential drugs

19. UNICEF continued to supply basic drugs such as aspirin, deworming medicine, iron and vitamin A supplements through the EPI programme. Essential drugs kits for commune infirmaries and district health centres have been supplied annually to approximately one third of the country in accordance with Ministry of Health priorities. Medicines were also provided through the RINE centres, the MCH programme and for the national anti-tuberculosis and yaws control programmes. A national essential drugs list was drawn up with UNICEF technical assistance, and therapeutic guidelines to improve utilization practices were prepared in Khmer for use at the commune level. UNICEF assisted in identifying priority areas for immediate and longer-term interventions by developing drug policy, strengthening training curricula and through drug management and logistics.

Health planning and management

20. UNICEF support to health planning and management increased in 1989. Basic equipment and transport for supervision in the provinces was provided to the Department of Curative and Preventive Medicine. A pilot project tested new registers and reports and improved the availability of morbidity and mortality data. An evaluation of this activity is planned for 1990. A specialist provided by UNICEF worked with the Government to analyse the development of PHC in the country. This effort yielded important findings on health training, human resources development, health planning and co-ordination.

Health education and communications

21. UNICEF has assisted the National Centre for Hygiene and Epidemiology of the Ministry of Health by producing posters and booklets and by training health workers in communication skills. Videos were produced to motivate the public about immunization, the control of diarrhoeal diseases (CDD) and sanitation. Assistance was also provided to the Women's Association for the production and distribution of health and nutrition readers for neo-literate women. The National Centre worked with UNICEF to improve the curricula and methodology for health staff training.

Nutrition and family food production

22. In addition to providing supplies and training funds for the supplementary feeding activities of the RINE centres, UNICEF assisted the MCH Division in developing and conducting nutrition surveillance of children under five years old in three districts of three provinces covered by the centres.

23. The family food production programme supported efforts to enhance household food production and security in seven provinces. Families received tools, seeds, fingerlings and poultry, and were motivated to dig ponds for gardening and fish

raising. Funds for staff training were also provided. Some 8,000 families, nearly 50 schools and 12 RINE centres have been covered. Progress has been slower than expected owing to limited manpower and inadequate co-ordination among institutions involved. The implementation of activities through the school system and the RINE centres has helped advocacy for improved nutrition in communities.

Rural water supply and sanitation

24. UNICEF co-operation initially focused on the rehabilitation of water and latrine systems in key institutions such as hospitals, schools, orphanages and teacher-training centres in Phnom Penh and neighbouring provinces. Attention was then given to drinking water supplies for the rural population and improvements in sanitation. In villages with a minimum population of 150-200, wells were dug or rehabilitated and equipped with hand-pumps. The installation of hand-pumps increased from 28 in 1983 to 993 in 1989. In 1989, a local adaptation of the Bangladesh No. 6 suction pump was produced in Phnom Penh and current production capacity is 300-400 per year. The local production of hand-pumps has resulted in a steady increase in the number and quality of wells and drilling rigs, as well as a growing base of experienced national drilling crews trained on the job. Latrine construction has been integrated into the programme on a pilot basis since 1986, and some 750 latrines were constructed locally and installed in rural areas of Phnom Penh, Kompong Speu and Kandal municipalities. Attention has also been given to education in hygiene and sanitation. Efforts have been made to involve women in the programme through the participation of community-based members of the Women's Association, through hygiene education and by encouraging women to become pump caretakers. UNICEF co-operated with the National Centre of Hygiene and Epidemiology in conducting hygiene education courses and in developing visual materials on hand-pump maintenance and repair. In 1989, 14 preventive health care courses were held for 630 health personnel in four provinces.

Primary education

25. UNICEF supported the education sector in enhancing the learning capacity and development of children. Equipment and supplies for the printing of textbooks were provided to the Publishing House of the Ministry of Education, personnel were trained and manuals, textbooks and readers on primary education were developed and produced. Production capacity in 1989 increased to 500,000 textbooks per year which is still far below the minimum annual requirement of 2 million.

26. The last of 10 provincial saw mills equipped by UNICEF for the production of school furniture became operational in 1989. UNICEF supplied technical equipment for a maintenance workshop intended to service the saw mills and organized training courses.

27. Health- and nutrition-related principles were introduced into the basic education cycle through the preparation of two new manuals. Similar messages were included in teacher-training courses. Science equipment and tools for subjects such as sewing and carpentry have been provided since 1986 to 28 teacher-training colleges, most of the lower secondary schools and a number of the 4,750 primary schools. Eight provincial teacher-training colleges were provided with video systems.

Women in development

28. Since 1985, UNICEF has co-operated with the Women's Association in the areas of CSD, health education, functional literacy and income generation. In 1989, 50,000 copies of 11 booklets for neo-literate women on CSD, women's health and family economy and agriculture were reproduced and distributed to 200 communes. Initial supplies were provided for income-generating activities such as sewing, silk-worm raising (in co-operation with the World Council of Churches), silk weaving, cow and pig husbandry and vegetable gardens. UNICEF also co-operated with the Groupe de recherches et échanges technologiques, an NGO, in the development of fuel-saving stoves for palm sugar processing. A pilot project on community-based child care was initiated in one commune in which literacy and income-generating activities were implemented. Assistance was also given for capacity building through workshops on CSD, income-generation, functional literacy and programme management and through study tours.

RECOMMENDED PROGRAMME CO-OPERATION, 1991

Recommended general resources: $2,500,000
Supplementary funds: $7,500,000

Recommended programme co-operation a/

(Thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	400	2 861	3 261
Water supply and sanitation	-	1 999	1 999
Nutrition	50	145	195
Household food security	150	420	570
Education	350	1 150	1 500
Women-centred programme	100	300	400
Children in especially difficult circumstances	70	150	220
Advocacy	35	282	317
Planning and social statistics	150	193	343
Programme support	1 000	-	1 000
Unallocated	195	-	195
Total	2 500	7 500	10 000

a/ The breakdown for estimated yearly expenditures is given in table 2.

b/ In addition, there are also funded supplementary funding projects shown in table 2.

Strategy of UNICEF co-operation

29. UNICEF co-operation supports national goals for improving the health and nutritional status of children; reducing maternal and child mortality and morbidity, as well as child malnutrition and disability; and improving the conditions for child development. Continuing previous programmes of assistance, UNICEF aims to develop an effective and efficient community-based delivery system, with priority given to activities that have a direct impact on child survival and the condition of women. Emphasis will be given to (a) reaching women and children in the unreached and hard-to-reach groups, including those suffering social, economic or physical deprivations and disabilities; (b) integrating capacity building into all major co-operation components; (c) activities that help children and women to meet their most immediate needs and that have reduced infant and child mortality; (d) selecting activities that are replicable in the country; (e) activities that seek to incorporate women in development, ensure community participation and actively involve NGOs in the delivery of basic services; and (f) continuing the concentration approach with a view to maximizing convergence and impact, focusing on the 11 central and southern provinces around Phnom Penh. With the changing political situation in the region, there may be more opportunities to help the country, subject to access and prevailing security conditions.

30. The primary areas of concentration are the 11 central and southern provinces around the city of Phnom Penh: Phnom Penh, Kompong Som, Kompong Thom, Kompong Chhnang, Kompong Cham, Kompong Speu, Kampot, Kandal, Takeo, Prey Veng and Svay Rieng. These provinces account for one third of Cambodia's land area and 74 per cent of its population. All elements of the country programme will be operational in this area in which there is relatively easy physical access.

31. A second area covers six provinces in the north, north-west, and west - Preah Vihear/Thbeng Meanchey, Siem Reap, Odder Meanchay, Battambang, Pursat and Koh Kong - which cover some 41 per cent of Cambodia's land area, but account for only 23 per cent of the population. In this area with its greater problems of security and access, attention will be focused on such key child survival components as immunization and oral rehydration. In anticipation of the return of the 300,000 border camp refugees to the area, other programme components will be considered as security and access allow.

32. A third area includes four sparsely populated provinces in the north-east with a primarily tribal and ethnic minority population: Stung Treng, Kratie, Mondolkiri and Ratanakiri. The area accounts for some 26 per cent of the land area, but only 3 per cent of the population. This remote area has considerable problems of physical access. In addition to supporting key child survival components, UNICEF will consider reaching this area through NGOs, with a specially designed package of integrated basic services.

Health

Child health

33. The main component under child health is EPI, which spearheads all child survival activities within the programme of co-operation. To date it is the only

health intervention with national coverage. The aim will be to further reduce infant and child morbidity and mortality from the six immunizable diseases and to reduce the incidence of neonatal tetanus. The child health programme will have nation-wide coverage along with EPI and will be delivered as part of a comprehensive package of child health services that includes CDD, the control of ARI, malaria and dengue fever. Main activities will include (a) the acceleration of vaccination in areas of low coverage and sustaining the 80 per cent immunization coverage; (b) accelerating the immunization of women of child-bearing age (15-45 years old) with tetanus toxoid; (c) the training of senior health personnel in EPI at all levels and annual refresher courses; (d) vaccine distribution by all available means of transport; and (e) the provision of adequate cold-chain equipment and replacement parts to all provinces. A national cold-chain survey will be carried out to determine its efficiency and vaccine potency at delivery. Disease surveillance will be improved through regular reporting. Social mobilization will be an important strategy for achieving higher coverage of immunization and other services. UNICEF will support the development and production of educational materials for this purpose.

34. Programme activities for CDD and the control of malaria and dengue will focus on the 11 provinces of concentration to achieve maximum impact on children. The training of all health personnel will be integrated with EPI training packages and will be carried out from the centre to the periphery. Guidelines for the case management of dehydration due to diarrhoea and for ARI will be produced for use at different levels, and health workers will be trained in their use. The preparation of home fluids for rehydration will be promoted through the training of health personnel. ORS will be distributed through the health system, primary schools and religious leaders. Knowledge, attitude and practice studies will be carried out to assess the impact of interventions. UNICEF will continue to support environmental health campaigns carried out by provincial health authorities and the Women's Association, and will promote the use of mosquito nets dipped in permethrin. Systematic monitoring will be enhanced through commune-level data collection and channeled to the central level. Quarterly monitoring reports will be prepared on the basis of selected indicators. Programme activities will be closely linked with those of the essential drugs and maternal health programmes, and co-ordination will be maintained with NGOs working in these fields.

Maternal health

35. Comprehensive maternal health care services will be supported in the 11 provinces of concentration through the training of secondary midwives and medical assistants at the Ecole centrale des cadres sanitaires. Curricula will be revised to include communication skills. Provincial midwifery schools will train commune-level midwives on the early recognition and management of maternal diseases. Primary midwives will be equipped with MCH kits. Support will be given to training in the planning and operational management of maternal health services, to provincial health personnel and to improve the supervision of maternal health services at district and sub-district (commune) levels. The Women's Association will be mobilized to ensure that women are referred to infirmaries at the early stages of pregnancy.

36. UNICEF will support the publication and distribution of practical guidelines to midwives, illustrated manuals to TBAs and health education leaflets on preventive measures to pregnant women. Social mobilization materials that promote antenatal visits and tetanus toxoid immunization will be provided to village activists, women's group leaders and Women's Association members. Maternal education activities at the village level will be supported through materials on birth spacing, breast-feeding, supplementary nutrition and weaning practices.

Essential drugs

37. Given the importance of adequate supplies of drugs to the effective functioning and utilization of basic health services, the essential drugs project will address the development of policy and management framework for all levels of the health system. Policies and guidelines will be developed and implemented for the control and rational utilization of drugs, and management systems will also be organized and implemented. Priority will be given to the 11 provinces of convergence where essential drugs will be provided. Managers and health workers will be trained and policy makers will be provided with technical assistance.

Integrated primary health care

38. This pilot project will provide the opportunity to test and evaluate the convergent PHC inputs in terms of increasing access to and the utilization of basic health services. It will allow for operational research, intensive monitoring and evaluation of an integrated health delivery system at all levels within a province. The project will focus on upgrading basic health services for children and mothers in one province for eventual expansion to other provinces. National programmes supporting province-level health services will be strengthened and tested as an integral part of the project. These programmes include planning and the implementation of a routine health information system which provides indicators for monitoring child health, health worker training and the development of PHC co-ordination and evaluation mechanisms.

Nutrition

39. UNICEF will assist in the planning and implementation of two closely linked projects. The target group will be lactating and pregnant women, and children under five years old, with special emphasis on the under-three age-group, in the 11 provinces. A survey of iodine deficiency disorders (IDD) scheduled for 1990 will provide the basis for a future national plan on IDD control.

Community-based nutrition

40. Monthly growth-monitoring sessions in all the districts and villages selected for this project will be used to provide (a) education to mothers on nutrition topics, including breast-feeding; (b) preventive services, including the distribution of vitamin A, immunization and prenatal check-ups; (c) therapeutic services, including the care of anaemic pregnant or lactating women; and (d) distribution of ORS packets. Community-supported rehabilitation feeding

projects will include community food gardens. The training of village volunteers and personnel at district, province and central levels will be multisectoral. The current nutrition surveillance system will be expanded and improved, and will form part of the early warning system for the identification of possible emergency situations.

Family food production

41. Family food security will be supported, with the objective of improving the nutritional status of children and women, especially the most vulnerable groups. Some 7,000 families (20 per village) will participate in the project, with priority given to poor and needy families. UNICEF will provide supplies and equipment to assist families in growing vegetables and cereals, planting trees for fuelwood, raising fish and poultry, digging wells and irrigation ponds, and improving soil with manure and compost. Food production activities will be introduced at health centres, rural schools, teacher-training centres, pagodas and orphanages and will be part of the curricula at training centres and schools. In order to enhance replicability, nurseries will be established in each district; local craftsmen will be supported in making farm tools and cement jars for drinking water, revolving funds will be established at the district level for use by participating families. Rice provided by the World Food Programme (WFP) under its food for work programme will be used to support labour involved in digging and rehabilitating fish ponds and wells.

Water supply and sanitation

42. The water supply, sanitation and hygiene programme for rural areas will be gradually expanded to the 11 provinces of concentration. Intersectoral co-operation in the planning, implementation, monitoring and evaluation of health education will be strengthened between the Ministry of Health and other relevant sectors and organizations involved in child survival, protection and development, including the Ministries of Education, and Information and Culture, the Women's Association and the mass media. This will contribute to a wider utilization of different communication channels for hygiene education, including health staff trained in communication techniques, the mass media, schools and political and religious organizations. Some 1,100 new wells will be dug, 240 old bore holes and hand-dug wells will be rehabilitated, and 1,500 new hand-pumps will be installed annually. The project will benefit some 350,000 people.

43. Water quality will be improved through the installation of iron removal plants and other appropriate technologies in problem areas. Some 4,500 family latrines will be installed in selected areas on a design adapted to local conditions. To increase latrine slab production, one workshop will be established in each of the concerned provinces. Community awareness of the importance of clean drinking water, sanitation and hygiene will be increased through sustained health education efforts using all channels of communication. In each province, trainers and supervisors will be trained in communication techniques. Management and administration will be improved through the training of responsible staff. Women will be increasingly involved in planning and other stages of the projects. Activities will be synchronized with those of other UNICEF-assisted and

health-related projects while the geographical concentration will facilitate supervision and the replication of effective experiences. Co-operation will be enhanced with the Ministries of Industry, Agriculture, and Information and Culture, as well as with the Women's Association and international NGOs.

44. UNICEF will support the provision of adequate supplies of safe water, sanitary latrines and drainage to priority public institutions in rural areas such as district hospitals, commune health centres, primary schools, teacher-training colleges, health cadres training schools and orphanages. Up to 430 tube-wells, 400 latrines and 26 rain water tanks will be set up. Reinforced by health education, these water and sanitation activities will provide examples for replication and behavioural change in the communities to which trainees will return.

Education

45. In previous years UNICEF has helped the Ministry of Education to achieve nearly full primary school enrolment. The effort now will be to sustain this achievement and to ensure that what children learn will be relevant to their lives, and that they stay long enough to benefit from an effective learning process. The most important component of UNICEF assistance will be improvement in the planning and management capability of the Ministry of Education, to produce a positive impact on the other interventions envisaged in the area of education.

46. UNICEF will continue to support both pre- and in-service teacher education, especially for new school subjects, nutrition and health. An important element in teacher education is the provision of teachers' manuals to be used in training courses and as reference books in classrooms. Assistance will be given to the textbook production system so that more durable books can be produced for primary school pupils and for teacher training. To reduce recurrent costs, teachers will be encouraged to use locally available materials for learning activities.

47. The learning and living environment in schools and teacher education institutes will be improved to include the provision of safe water and sanitation and the improvement of boarding facilities for female student teachers. Classroom materials such as blackboards and desks will be provided. The potential for learning by preparing and distributing audio cassettes will be taken into consideration.

48. Adult education will concentrate on girls and young women who were unable to complete their primary education. An important element in this field is the inclusion of material on early childhood care and development, with particular emphasis on community-based centres. Mothers and other family members will be taught ways in which development can be stimulated in and around the home.

Women in development

49. Since women in Cambodia play an important role in all areas of UNICEF concern, women's activities will be given increased attention in all components of the country programme. Women will be the major target group for all health and nutrition programmes. The water, sanitation and hygiene programme will incorporate

special measures to encourage increased female participation in formal and non-formal education and will work together with the Women's Association to promote female literacy, community-based child care and early childhood development.

50. UNICEF will continue to support the integration of women into all development programmes and to provide them with the knowledge required to improve their children's situation. In co-operation with the Women's Association, functional literacy will be enhanced through the production of booklets focusing on health, CSD and income-generating and agricultural activities. Literacy groups will be increased to cover 100 additional sub-districts. Health, hygiene and nutrition education courses will be given to community groups in sub-districts of the 11 provinces of convergence and in Pursat. Support for income-generating activities will continue and community child care will be promoted in selected villages. Training sessions in programme development, implementation and monitoring of women's programmes will be held for women's group leaders and cadres of the Women's Association.

Programme communications

51. Sustained, effective communications materials will be produced to support CSD programmes and for women's literacy and income-generating activities. The mass media, including film, radio and video, will be assisted with equipment and training to increase the production of messages using Facts for Life material in support of these programmes. The capacity of the Women's Association to provide effective support for CDD, MCH, and literacy activities will be enhanced through training, and a media unit will be established within the Association. Training will also be given to the staff of the newly established School Broadcasting Unit of the Ministry of Education.

Children in especially difficult circumstances

52. A community-based rehabilitation project will be planned and implemented along the lines of the 1986 UNICEF-assisted, pilot rehabilitation project in selected sub-districts (communes) in the provinces of Kandal and Kompong Speu. Those projects were reviewed and assessed by UNICEF consultants who recommended their continuation and expansion. A UNICEF/Rehabilitation International consultant will assist in planning and training activities as well as in the review and consolidation of activities in the two existing community-based rehabilitation project provinces.

53. Priority will be given to a survey of children and young adults who were affected by the psychological trauma resulting from being subjected to or witnessing atrocities in the 1970s in areas of conflict to determine the magnitude and severity of the problem. The Government will be assisted by a consultant at the outset of the programme.

Social statistics

54. UNICEF will assist the Department of Statistics of the Ministry of Planning and the statistical services of other social sector ministries in improving the

availability, quality and use of special-purpose data in CSD activities. Based upon a needs assessment for capacity building in social statistics, the specialized training of relevant personnel will be carried out. A national sample survey on the situation of children will be planned for use in subsequent years. The Ministry of Planning and UNICEF will co-operate in the establishment of a joint country programme planning, monitoring and review process. UNICEF will provide basic equipment, supplies, library and information support, as well as opportunities for experience exchange.

Monitoring and evaluation

55. The National Committee for the Reception of Humanitarian Aid will guide the general evaluation of the programme and oversee all logistical arrangements for the reception and distribution of UNICEF assistance. Periodic review meetings with sectoral authorities will take place, along with joint assessment reviews. In addition to regular monitoring activities, UNICEF will also carry out spot checks. In areas such as water, EPI and family food production, monitoring activities will be supplemented through field visits by national counterparts and UNICEF staff, together with local and governmental authorities. During the annual progress reviews by the authorities and UNICEF, a plan of action for the following year will be prepared, which will include recommendations for modifications of policies, procedures, training materials and educational approaches.

Co-operation with other organizations

56. United Nations bodies providing assistance to Cambodia include UNICEF, WFP and the Office of the United Nations High Commissioner for Refugees. The Food and Agriculture Organization of the United Nations provides emergency assistance when necessary. Also present are the International Committee of the Red Cross (ICRC) and NGOs which provide assistance in the fields of health, agriculture and education, complementing UNICEF assistance for children and mothers. UNICEF co-operates closely with a number of these, especially ICRC, World Vision, Groupe de recherches et échanges technologiques, Enfants du Cambodge, Australian Save the Children Fund, Catholic International Co-operation for Development and Solidarity and the Japan International Volunteer Centre. Exchange of information and co-operation is maintained with these NGOs through weekly meetings, and inter-agency groups meet frequently in sectors such as health, nutrition and water supply. ICRC and UNICEF co-operate closely in logistical and related issues.

57. UNICEF supports the Office of the Special Representative of the Secretary-General for Co-ordination of Cambodian Humanitarian Assistance and prepares the missions of the Special Representative and his colleagues and field trips in the country.

CAMBODIA

Basic data: 1988 and earlier years

			UNICEF country classification
Under-five mortality rate	199	(1988)	Very high U5MR
Infant mortality rate	127	(1988)	Very high IMR
GNP per capita	70	(1974)	Low GNP
Total population	8 million	(1988)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1988
Births	(thousands)	284	257	316	319
Infant deaths (under 1)	(thousands)	44	54	46	40
Under-five deaths	(thousands)	69	85	71	63
Under-five mortality rate (per 1,000 live births)		243	330	226	199
Infant mortality rate (under 1) (per 1,000 live births)		155	211	145	127

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1987)	Moderate & severe	32*	20
	Severe	5*	3
Babies with low birth weight (%)		..	..
Children completing primary level (% of first grade, 1986)		..	50*

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1987)		../../..	100/93/72
Prevalence of wasting (%, 1985)		..	..
Prevalence of stunting (%)		..	..
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)		84	98
Food production per capita index (Index 1979-1981=100, 1980/1988)		114	141
Household expenditure (% of total income)	All food/cereals	../..	../

HEALTH INDICATORS		About 1980	Most recent
ORS use rate (%, 1986-1987)			6
Access to health services (% of population, 1986)	Total	..	53*
	Urban/rural	../..	80*/50*
Access to safe water (% of population, 1986)	Total	..	3*
	Urban/rural	../..	10*/ 2*
Access to adequate sanitation (% of population)	Total	..	..
	Urban/rural	../..	../..
Births attended by trained personnel (%, 1984)		..	47
Maternal mortality rate (per 100,000 live births)		..	..

Immunization		1981	1985	1987	1988
One-year-olds (%) immunized against:	Tuberculosis	..	57	54	56
	DPT	..	23	37	45
	Polio	..	26	35	45
	Measles	..	29	54	38
Pregnant women (%) immunized against	Tetanus	..	21	3	3

CAMBODIA

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	199	(1988)	Very high U5MR
Infant mortality rate	127	(1988)	Very high IMR
GNP per capita	70	(1974)	Low GNP

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%)	Total	../..	.. /..
	Male	../..	.. /..
	Female	../..	.. /..
Secondary enrolment ratio (gross/net) (%, 1986)	Total	../..	33*/..
	Male	../..	45*/..
	Female	../..	20*/..
Adult literacy rate, 15 years & older (%, 1970/1985)	Total	..	75*
	Male/female	../23	85*/65*
Radio/television sets (per 1,000 population, 1980/1987)		94/ 6	106 / 8

DEMOGRAPHIC INDICATORS		1970	1980	1985	1988	2000**
Total population	(millions)	6.9	6.4	7.3	7.9	10.0
Population aged 0-15 years	(millions)	..	2.3	2.6	2.8	4.1
Population aged 0-4 years	(millions)	..	0.4	1.3	1.4	1.3
Urban population (% of total)		12	10	11	11	15
Life expectancy at birth (years)	Total	43	37	46	49	55
	Male/female	42/44	36/39	45/47	48/50	53/56
Total fertility rate		5.9	4.6	4.9	4.7	4.0
Crude birth rate (per 1,000 population)		42	38	43	41	28
Crude death rate (per 1,000 population)		21	30	18	16	12

		About 1980	Most recent
Contraceptive prevalence rate (%)		..	..
Population annual growth rate (%, 1965-1980/1980-1988)	Total	0.3	2.6
	Urban	1.9	3.8

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%)		..	..
Inflation rate (%)		..	..
Population in absolute poverty (%)	Urban/rural	../..	../..
Household income share (%)	Top 20%/bottom 40%	../..	../..
Government expenditure	Health/education	../..	../..
(% of total expenditure)	Defence	..	..
Household expenditure (% of total income)	Health/education	../..	../..
Official development assistance: (1980/1987)	US$ millions	281	14
	As % of GNP	..	..
Debt service (% of goods & services exports)		..	..

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

**, United Nations Population Division projections based on past and current trends.

/...

TABLE 1. BREAKDOWN OF ACTUAL EXPENDITURE FOR GENERAL RESOURCES AND SUPPLEMENTARY FUNDING UNDER PREVIOUS CO-OPERATION PERIOD, 1989

(Thousands of United States dollars)

COUNTRY: CAMBODIA
LATEST BOARD APPROVAL: 1989 for 1990
GENERAL RESOURCES: $2,500,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	SF	GR	SF	GR	SF	GR	SF	GR	SF	Total
Health	726	739	3	61			26	33	755	833	1588
Water supply and sanitation	264	375			47	51	2	6	313	432	746
Nutrition	36	47	1	1			10	87	47	136	182
Education	96	104	1				7	54	105	158	263
Community organization and development		1						26		27	27
Women-centred programme	31	44	2				3	8	37	51	88
Planning and project support	41		1		127	46	628		797	46	843
Freight	1						3		4		4
GRAND TOTAL	1196	1310	9	63	174	97	681	213	2059	1683	3742

GR = General resources.
SF = Supplementary funding.

TABLE 2. PLANNED EXPENDITURE FOR GENERAL RESOURCES, NEW SUPPLEMENTARY FUNDING AND FUNDED SUPPLEMENTARY FUNDING

(Thousands of United States dollars)

Country: CAMBODIA Period covered: 1991	Funding status	1991	1992	1993	1994	1995	Total
Health							
Immunization	GR	75					75
	NSF	1020					1020
Control of diarrhoeal diseases	NSF	105					105
Other health	GR	325					325
	NSF	1736					1736
Subtotal, health	GR	400					400
	NSF	2861					2861
Water supply and sanitation	NSF	1999					1999
Nutrition	GR	50					50
	NSF	145					145
Household food security	GR	150					150
	NSF	420					420
Education	GR	350					350
	NSF	1150					1150
Women-centred programme	GR	100					100
	NSF	300					300
Children in especially difficult circumstances	GR	70					70
	NSF	150					150
Advocacy	GR	35					35
	NSF	282					282
Planning and social statistics	GR	150					150
	NSF	193					193
Programme support	GR	1000					1000
Unallocated funds	GR	195					195
TOTAL	GR	2500					2500
	NSF	7500					7500
GRAND TOTAL		10000					10000

GR = General resources.
NSF = New supplementary funding.

/...

TABLE 3. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: CAMBODIA	APPROVED 1990-1991		PROPOSED 1991	
	Number of posts	amount (Thousands of US dollars)	Number of posts	amount (Thousands of US dollars)
FINANCED FROM 1990-1991 APPROVED BUDGET:				
International Professional established posts				
Local national Professional and General Service established posts				
Operating costs				
Total				
FINANCED FROM PROGRAMME FUNDS: a/				
International Professional project posts				
General resources	6	1153	6	604
Supplementary funds	3	545	12	1109
Local national Professional and General Service project posts				
General resources	3	325	8	412
Supplementary funds	1	108	3	144
Total	13	2131	29	2269

a/ For information source, see 1990 post authorization table, revised October 1989.